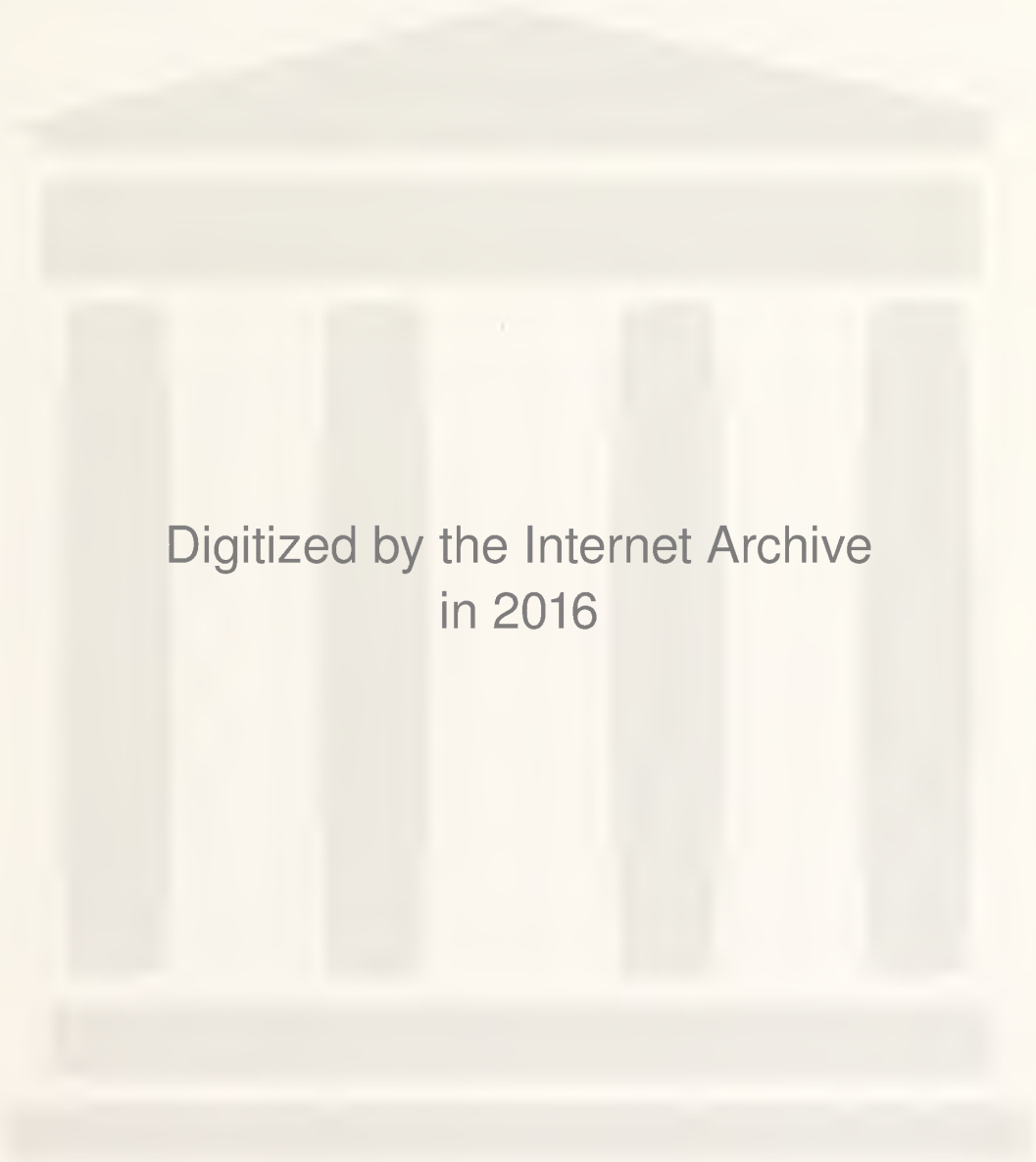

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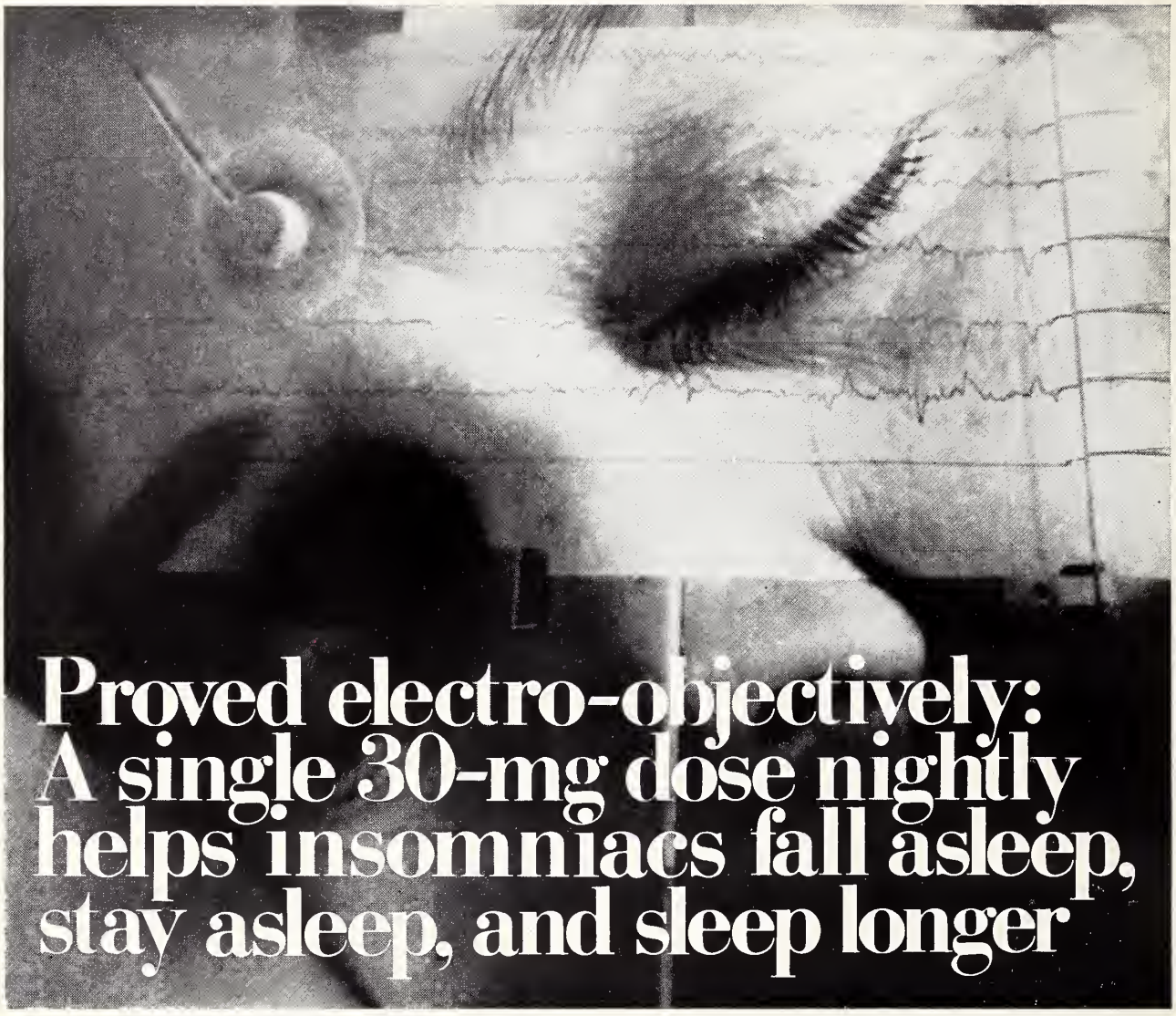
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OF THE INDIANA STATE MEDICAL ASSOCIATION



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Proved electro-objectively: A single 30-mg dose nightly helps insomniacs fall asleep, stay asleep, and sleep longer

Controlled studies of 23 insomniac and 13 normal subjects treated with Dalmane (flurazepam HCl) in five sleep laboratories generated over 4000 hours of electroencephalographic, electro-oculographic and electromyographic tracings. These studies revealed that Dalmane 30 mg nightly usually induces sleep in 22 minutes and provides seven to eight hours of sleep.[1,2,3]

Moreover, Dalmane 30 mg was found to be useful in all common types of insomnia in which it was studied. Of drugs studied in a sleep laboratory,[1] Dalmane 30 mg was the only one that consistently reduced sleep induction time and maintained sleep nightly for 14 consecutive nights of use.

Confirmed clinically

Fifty-three controlled studies using a paired-night, double-blind crossover design have evaluated Dalmane clinically. In the majority of these, Dalmane (flurazepam HCl) significantly reduced sleep induction time and increased sleep duration. Dalmane and a placebo were alternated on successive nights in 2010 insomniacs, 1706 of whom were studied for a single night-pair, and the remainder for as many as fifteen paired-nights. A patient preference for Dalmane was apparent in the paired-night studies.

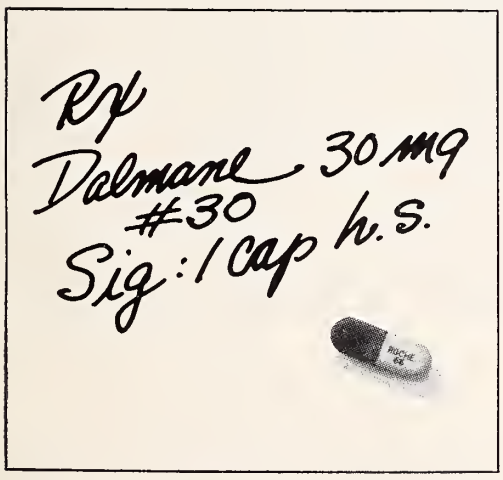
Dalmane was also preferred to certain hypnotics in two separate preference studies. In each of two double-blind studies, Dalmane 30 mg retained effectiveness for the total period of seven consecutive treatment nights, according to subjective/objective evaluations.

In summary, Dalmane is useful in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening. It can be used effectively in patients with recurring insomnia or poor sleeping habits, and in acute or chronic medical situations requiring restful sleep.

Dalmane (flurazepam HCl) is generally well tolerated

In most instances in which adverse effects with Dalmane were reported, they were mild, infrequent and seldom required discontinuation of the drug. Dizziness, drowsiness, lightheadedness and the like were the side effects most frequently noted, particularly in elderly or debilitated patients.[3] Instances of hepatic dysfunction, paradoxical reactions (excitement) and hypotension are rare with Dalmane, and morning hang-over is relatively infrequent. In studies to date the effectiveness of Dalmane for recommended periods of use is maintained without need to increase dosage.

References: 1. Kales, A., *et al.:* "Effectiveness of Sleep Medications: All-Night EEG Studies of Hypnotic Drugs," in Proc. 7th Internat. Cong. Electroencephal. and Clin. Neurophysiol., San Diego, Calif., Sept. 13-19, 1969. **2.** Kales, A., *et al.:* "Psychophysiological and Biochemical Changes Following Use and Withdrawal of Hypnotics," in Kales, A. (ed.): *Sleep: Physiology and Pathology,* Phila., Lippincott, 1969, p. 331. **3.** Data on file, Medical Department, Hoffmann-La Roche Inc.



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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.,* excitement, stimulation and hyperactivity, have also been reported in rare instances.

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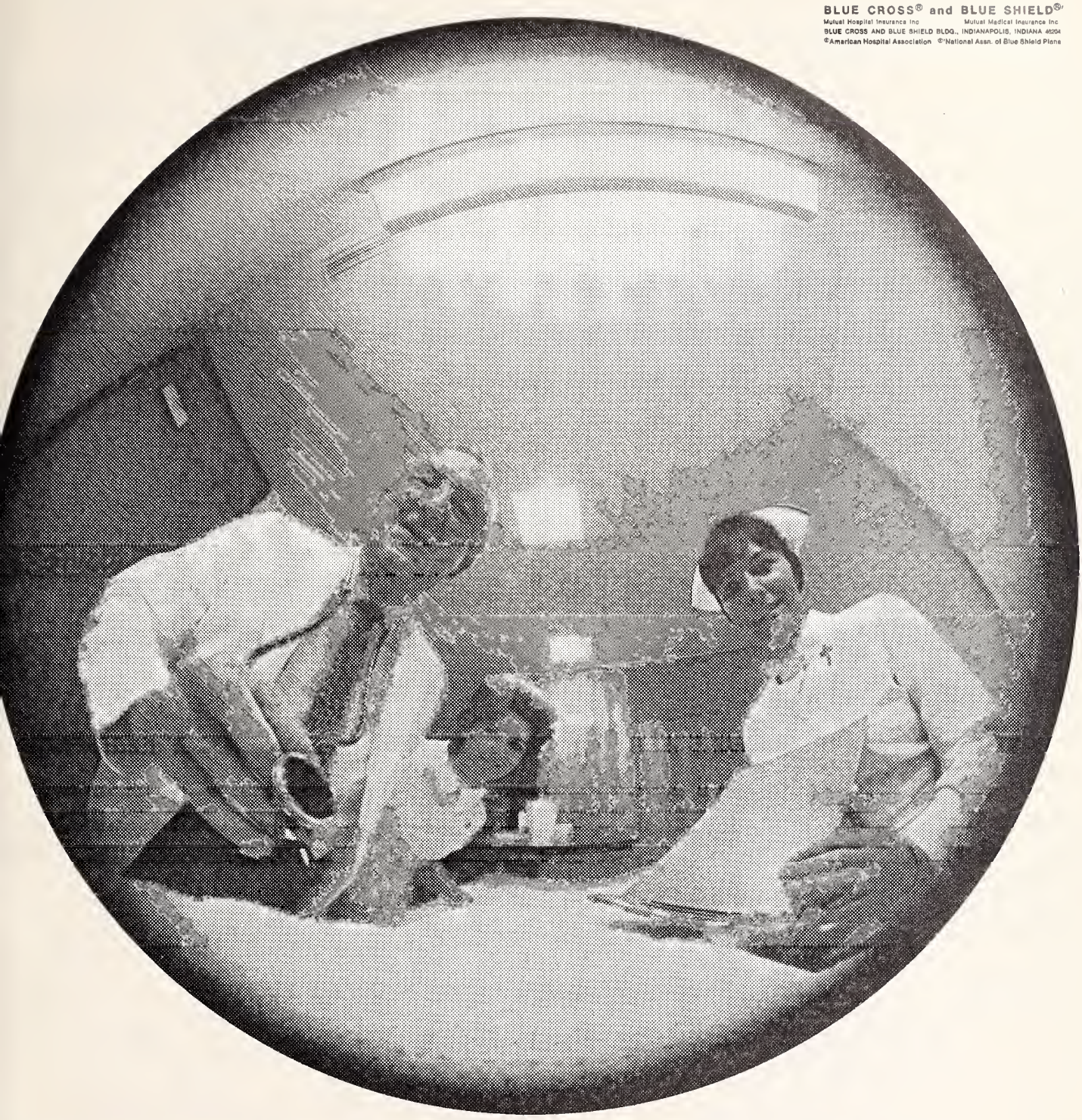
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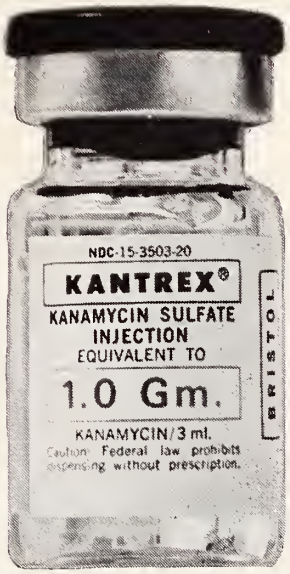
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A dozen years of Kantrex usage have established its efficacy, its versatility, its simplicity.

And its economy.

Faced with a life-threatening infection, the physician cannot conscionably consider economy a primary factor in selection of an appropriate antibiotic. However, when susceptibility reports are in, the infecting pathogens are often found to be susceptible to several antibiotics. The physician may then consider dose requirements and cost in his prescribing decision.

Kantrex requires one simple standardized dose for almost any patient with any susceptible mixed Gram-negative/staph infection (Pseudomonas are resistant). The usual adult daily dose of Kantrex is only 1.0 Gm.... and the usual total course of therapy, 7-10 Gm. Translated to dollars and cents, the daily cost of Kantrex therapy may be only 1/2 to 1/8 that of therapy with other parenteral antibiotics used for serious hospital infections.

Doesn't it make good sense to use Kantrex?

Experience proves it does.

BRIEF SUMMARY OF PRESCRIBING INFORMATION
(8) 7/8/70
For complete information, consult Official Package Circular.

Warning: Irreversible deafness can occur. Tinnitus or vertigo may also occur and indicate vestibular damage and impending deafness. The risk is sharply increased with renal dysfunction. In such cases, decrease size and frequency of doses. Discontinue kanamycin and check hearing if azotemia increases. Watch carefully for ototoxicity in older patients and patients receiving more than 15 Gm. of kanamycin. To avoid neuromuscular paralysis with respiratory depression, postpone intraperitoneal instillation in post-operative patients until recovery from anesthesia and muscle relaxants is complete. Avoid concurrent use of other ototoxic drugs including ethacrynic acid. Safety in pregnancy is not established.

Indications: Serious infections due to susceptible strains of *E. coli*, Proteus sp., *Enterobacter aerogenes*, *K. pneumoniae*, *Serratia marcescens* and *Mima-Herellea*. Culture and sensitivity studies should be performed.

Contraindications: A history of hypersensitivity to the drug. Prior auditory damage by kanamycin or other agents may be a contraindication if effective alternative therapy is available.

Precautions: Obtain audiograms before and during therapy in patients with renal dysfunction when treatment lasts more than 5 days. Stop Kantrex if tinnitus or hearing loss occurs. Hydrate patients to prevent chemical irritation of the renal tubules. Assess renal function periodically, both before and during therapy. If signs of renal irritation occur (casts, cells, proteinuria) increase hydration and reduce the dosage or the frequency of dosage if necessary—in azotemic patients the frequency (in hours) of doses may be obtained by multiplying the serum creatinine by 9. If azotemia or oliguria occur, discontinue therapy. Mycotic or bacterial superinfection may occur.

Adverse Reactions: Irritation or pain at the injection site, skin rash, drug fever, headache and paresthesias.

Dosage and Administration: The maximum total daily dose should not exceed 1.5 Gm. by all routes of administration. The usual dose is 7.5 mg./Kg./12 hours I.M. The average adult dose is 1 Gm. daily. Uncomplicated infections due to sensitive organisms should respond in 24 to 48 hours.

If no response occurs in 3 to 5 days, stop therapy and recheck the bacterial sensitivities. Hydrate patients well to minimize renal irritation. Inject deeply into the upper outer quadrant of the gluteal muscle. Discard partially used vials after 48 hours. The drug should not be physically mixed with other antimicrobials.

Supplied: Rubber capped vials as a ready-to-use sterile aqueous solution in two concentrations: 0.5 Gm. in 2 ml. and 1.0 Gm. in 3 ml. Also available—Pediatric Injection 75 mg. in 2 ml.

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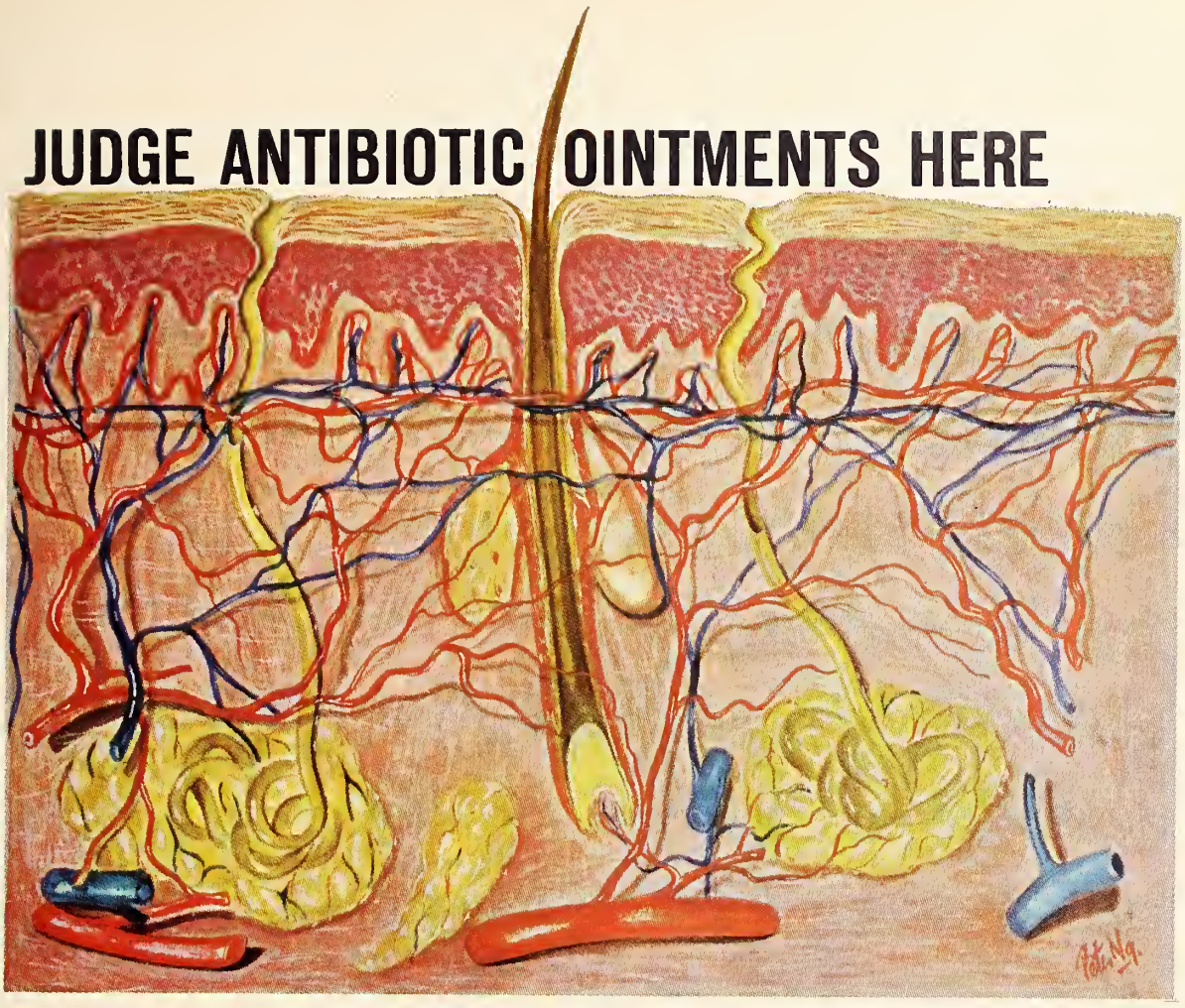
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Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

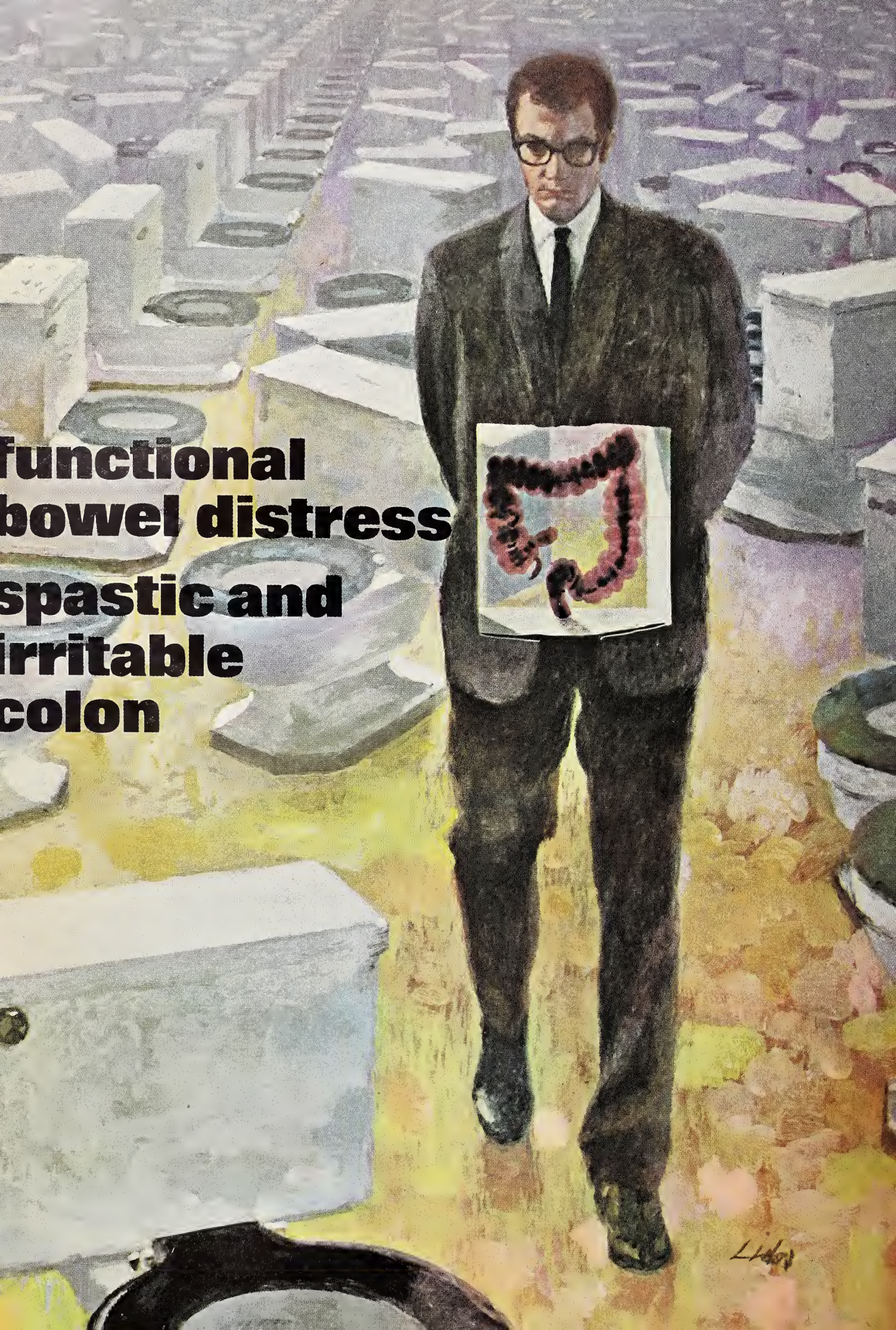
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In treating hypermotility associated with functional lower G-I disorders are you disappointed in the results you've been getting with some of the synthetics? Then *move up* to a potent antispasmodic—Robinul® Forte (2 mg. glycopyrrolate). It provides prompt, pronounced, prolonged suppression of hypermotility, making it a highly effective agent in functional bowel distress, as well as in spastic and irritable colon. Robinul Forte also exerts a more selective action on the gastrointestinal tract. If the patient has a "one tract mind" concerning his lower G-I symptoms, you can help control the anxiety and tenseness by prescribing Robinul®-PH Forte (2 mg. glycopyrrolate with 16.2 mg. phenobarbital —warning: may be habit forming).

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INDICATIONS Robinul Forte (glycopyrrolate, 2 mg.) and Robinul-PH Forte are double-strength dosage forms of glycopyrrolate. They are primarily indicated for patients who are less responsive to anticholinergic therapy and for control of the more prominent symptomatology associated with acute episodes of gastrointestinal disorders. Emphasis should be on total management, with due consideration of the various therapeutic modalities available, including diet, antacids, anticholinergic agents, sedatives, and attention to emotional problems. Accordingly, glycopyrrolate is recommended in the management of gastrointestinal disorders amenable to anticholinergic therapy, such as: (1) duodenal ulcer, duodenitis, pylorospasm; (2) gastric ulcer, gastritis, esophageal hiatal hernia, hyperchlorhydria, pyrosis, aerophagia, gastroenteritis; (3) esophagitis; (4) cholecystitis, chronic pancreatitis; (5) spastic and irritable colon, ulcerative colitis, functional bowel distress, diverticulitis, acute enteritis, diarrhea; and (6) splenic flexure syndrome, neurogenic gastrointestinal disturbances. When these conditions are associated with psychic overlay, the formulation with phenobarbital may be indicated. ■ **CONTRAINDICATIONS** Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte (glycopyrrolate with phenobarbital), sensitivity to phenobarbital. ■ **PRECAUTIONS** Administer with caution in the presence of incipient glaucoma. ■ **SIDE EFFECTS** The most frequent side effect noted during clinical trials was dry mouth. Thirty-three (3.3%) of 1,009 patients receiving 1 to 32 mg. of glycopyrrolate a day complained of dry mouth of moderate to severe degree, but only 11 discontinued treatment because of this. Blurred vision, constipation, and urinary hesitancy have been reported infrequently. Other side effects associated with the use of anticholinergic drugs include: tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash. ■ **DOSAGE** The average and maximum recommended dose of Robinul Forte (glycopyrrolate, 2 mg.) or Robinul-PH Forte is one tablet three times daily (in the morning, early afternoon, and at bedtime). To obtain optimum results, dosage should be adjusted to the individual patient's response. After the more severe symptoms associated with acute conditions have subsided, the dose may be reduced to the minimum required to maintain symptomatic relief. ■ **SUPPLY** Robinul Forte (glycopyrrolate, 2 mg.) is available as scored, compressed pink tablets engraved AHR/2 in bottles of 100 and 500. ■ Robinul-PH Forte (glycopyrrolate, 2 mg., with phenobarbital, 16.2 mg.) is available as scored, compressed blue tablets engraved AHR/2 in bottles of 100 and 500.

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(Each tablet contains 25 mg. of phenylephrine hydrochloride and 4 mg. of chlorpheniramine maleate.)

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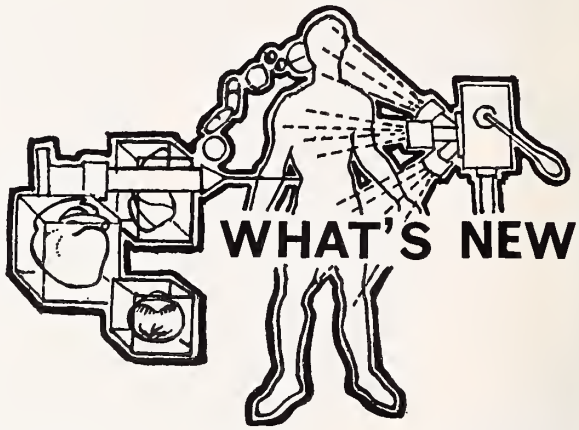
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"He's mentioned in this issue."



WHAT'S NEW?

Parke-Davis announces a new film-coated tablet designed to treat iron deficiency anemia as well as foliate deficiency. Tabron Filmseal is their first major film-coated tablet product. The film-coating method applies a nonaqueous solution of water-soluble polymeric materials to the tablets without affecting the sensitive vitamins inside.

* * *

Stryker has an improved model of the CircOlectric bed for immobilized patients. The new footboard is adjustable so that it fits regardless of height of the patient and is comfortable in either lying or sitting positions. A new adjustable crossbar brings the anterior frame snugly against the patient, whether thin or obese.

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Ditto Industries has a small but powerful, portable table-top horizontal vise suitable for securing and clamping a variety of objects to facilitate drilling, welding, soldering or filing. Originally intended for use by hobbyists and industrial concerns it has been found to be popular with medical laboratories. Write Barry R. Ditto, 527 N. Alexandria Ave., Los Angeles 90004.

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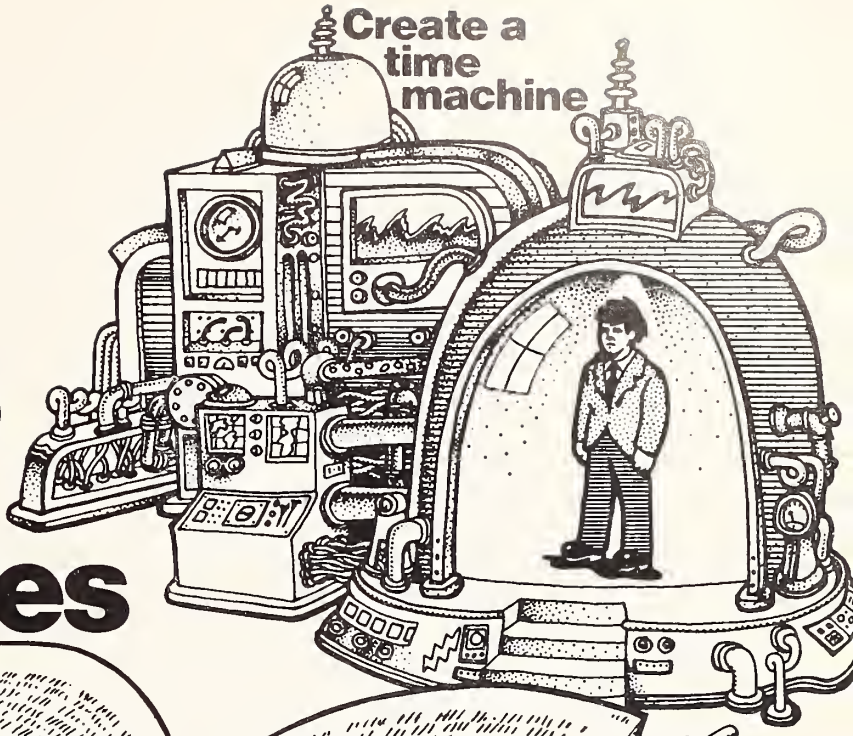
Mead Johnson announces a new sequential oral contraceptive—Oracon-28. Each package supplies 28 pills, one to be taken each day. The cycle starts with 16 white tablets of 0.1 mg ethinyl estradiol, followed by 6 pink tablets of 0.1 mg ethinyl estradiol and 25 mg dimethisterone, followed by 6 green inert tablets.

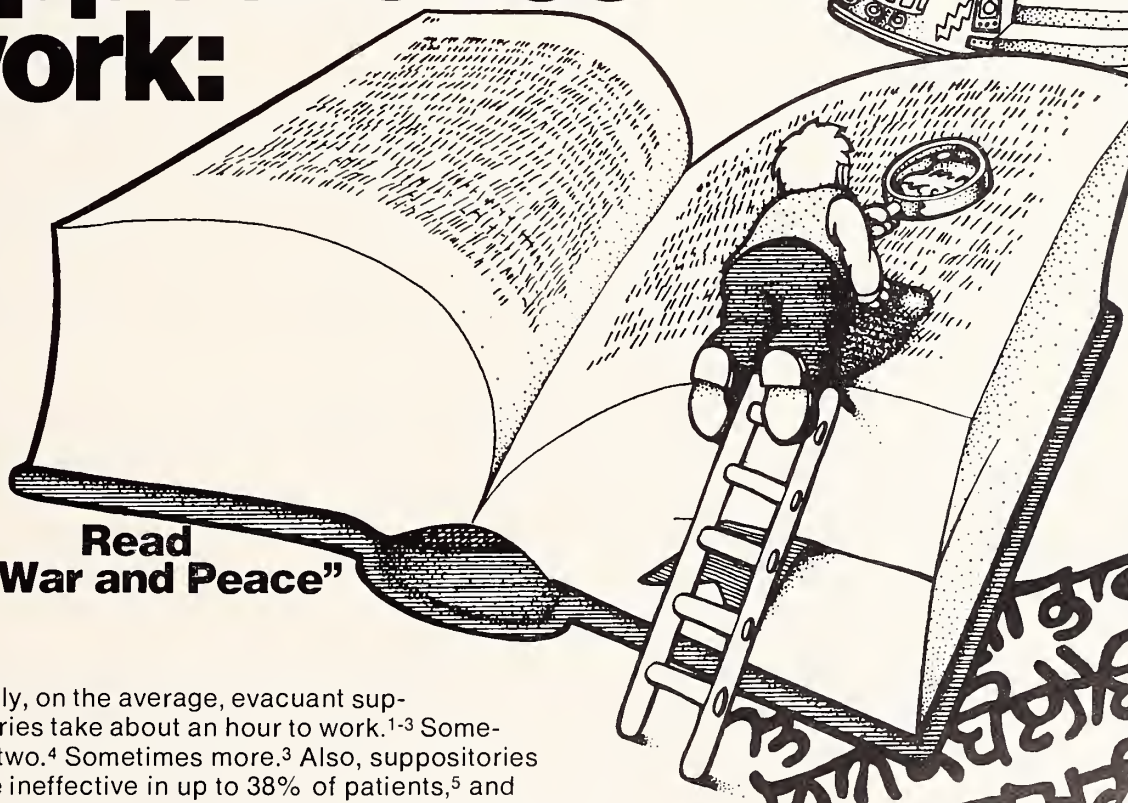
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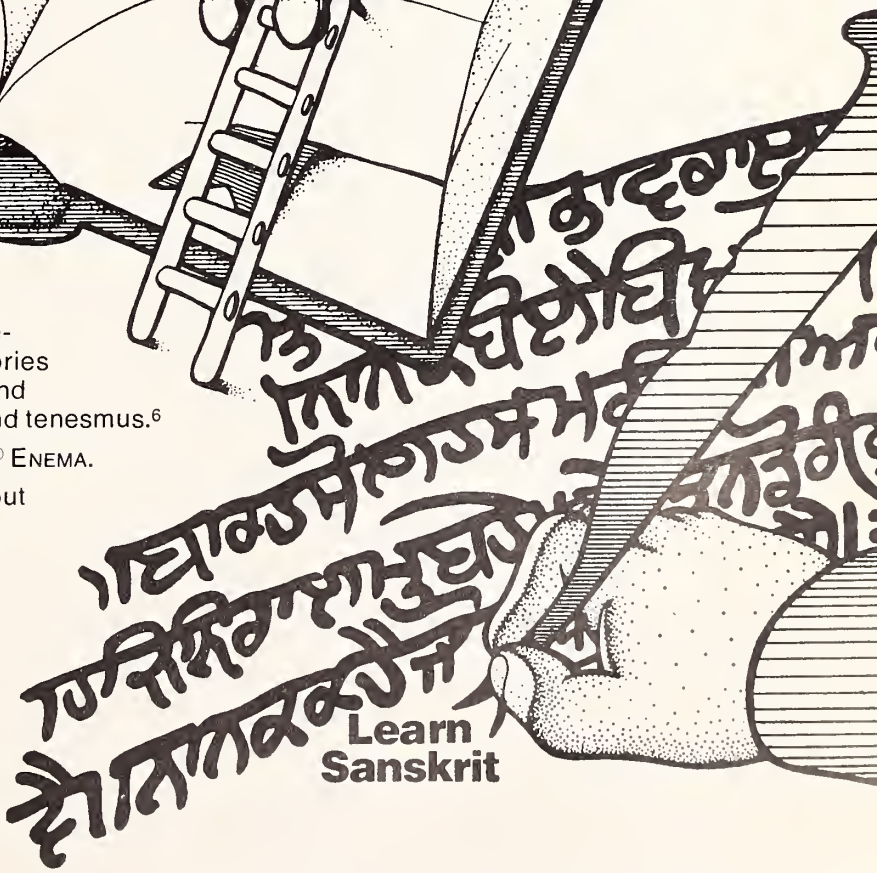
Ames announces a new and improved method of measuring T-4. The new test, TETRALUTE®, requires fewer steps and less time than older methods. It measures total thyroxine in serum—both free and bound—giving information comparable to the more complicated PBI procedure.

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments, and surgical appliances and book publishers. Each item is published as news and does not necessarily constitute an indorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

What to do until suppositories work:







Actually, on the average, evacuant suppositories take about an hour to work.[1-3] Sometimes two.[4] Sometimes more.[3] Also, suppositories can be ineffective in up to 38% of patients,[5] and not infrequently produce smarting, burning and tenesmus.[6]

Alternative to the long unpleasant wait: FLEET® ENEMA.

FLEET ENEMA works within 2 to 5 minutes without pain or spasm. FLEET ENEMA induces a physiological pattern of evacuation, unlike purgatives and laxatives that may liquefy the stool. FLEET ENEMA avoids the irritation common with soapsuds enema. And FLEET ENEMA is leakproof: a rubber diaphragm at the base of the prelubricated tube prevents seepage and controls the rate of flow, assuring comfortable administration.



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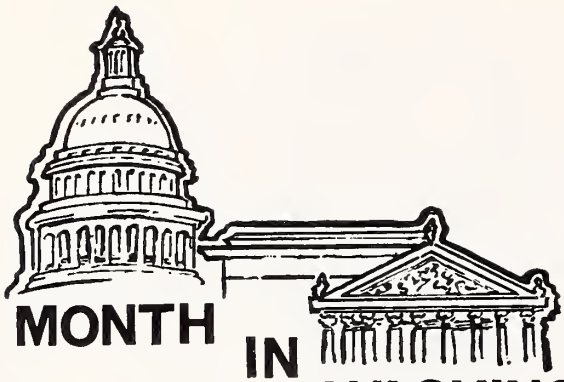
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Warning: Frequent or prolonged use of enemas may result in dependence. Take only when needed or when prescribed by a physician. Do not use when nausea, vomiting or abdominal pain is present.
Caution: Do not administer to children under two years of age unless directed by a physician.

References: 1. Blumberg, N.: Med Times 91:45, Jan., 1963. 2. Sweeney, W. J., III: Amer J Obstet Gynec 85:908, Apr. 1, 1963. 3. Weinsaft, P.: J Amer Geriat Soc 12:295, Mar., 1964. 4. Baydoun, A. B.: Amer J Obstet Gynec 85:905, Apr. 1, 1963. 5. Feder, I. A., Flores, A. and Weiss, J.: Amer J Gastroent 33:366, Mar., 1960. 6. Smith, J. J. and Schwartz, E. D.: Western J Surg 72:177, May-June, 1964.

F19A73



MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

THE HOUSE WAYS AND MEANS Committee has approved the Social Security Amendments of 1971 (Medicare and Medicaid changes) and sent the massive health bill to the floor of the House for expected early passage.

AS ADOPTED by the committee, the bill concerns itself with the implementation of the Administration's Health Maintenance Organization option for Medicare beneficiaries, restricts physicians' fee increases under federal programs, reduces some long-term Medicare benefits, and covers under Medicare for the first time disabled social security beneficiaries.

THE SECRETARY WOULD ALSO be authorized to conduct experiments with areawide or communitywide peer review, utilization review and medical review mechanisms.

CONGRESS FAILED to pass substantially the same bill during the last session due to major differences between the House and Senate versions and the lack of time to reach agreement.

MEDICARE BENEFICIARIES would be permitted to have all covered care provided by a Health Maintenance Organization (HMO), defined as a prepaid group health or other capitation plan, with the government reimbursing the HMO's at 95 per cent of the average cost of Medicare beneficiaries in the area.

PHYSICIANS' Medicare fees would be pegged at the 75th percentile of actual charges in a locality and future increases would be tied to a special index reflecting rising costs. The Department of Health, Education, and Welfare could terminate payments to providers found guilty of program abuses.

A MEDICARE CO-INSURANCE factor one-eighth of the hospital deductible would be applied after the 30th day. The Medicare part B deductible would rise to $60 a year and medically indigent persons above the poverty level could be required by the states to pay an income-related premium.

OTHER FEATURES of the proposed legislation:

—HEW would be required to develop experiments and demonstration projects designed to test payment to providers of services on a prospective basis under the Medicare, Medicaid, and maternal and child health programs.

—Limits on institutional provider costs to be recognized as reasonable under Medicare could be imposed based on comparisons of the costs of covered services by various classes of providers in the same geographical area.

—Medicare would pay for the services of teaching physicians on the basis of reasonable costs, rather than fee-for-service charges, unless a bona fide private patient relationship had been established or the hospital had, in the two-year period ending in 1967 and subsequently customarily charged all patients and collected from at least 50% of patients on a fee-for-service basis. Medicare payments could also be authorized on a cost basis for services provided to hospitals by the staff of certain medical schools.

—HEW would be authorized to establish minimum periods of time (by medical condition) after hospitalization during which a patient would be presumed, for payment purposes, to require extended care level of services in an extended care facility. The attending physician would certify to the condition and related need for the services. A similar provision would apply to post-hospital home health services.

—Present penalty provisions relating to the making by providers of care of a false statement or representation of a material fact in any application for Medicare payments would be broadened to include the soliciting, offering or acceptance of kickbacks or bribes, including the rebating of a portion of a fee or a charge for a patient referral. The penalty for such acts, as well as the acts currently subject to penalty under Medicare, would be imprisonment up to one year, a fine of $10,000, or both. Similar penalty provisions would apply under Medicaid.

—HEW would conduct a two-year study of the desirability of covering chiropractors' services under Medicare.

THE BILL ALLOWS the HEW Secretary to authorize experiments with methods of Medicare reimbursement or payment, "with areawide or community-wide peer review, utilization review and medical review mechanisms," and with performance incentives for intermediaries and carriers.

ANOTHER SECTION of the catch-all bill of wide public interest would establish a new family assistance welfare plan. The bill also increases social security case benefits and taxes.

HOUSE APPROVES BILL TO MEET MEDICAL PERSONNEL SHORTAGE

THE HOUSE COMMITTEE on Interstate and Foreign Commerce has approved a three-part health bill designed to meet the national shortage of medical personnel by 1978.

THE PROPOSED LEGISLATION would authorize an estimated $3.3 billion in aid to health profession students and their schools in the next three years and provide the facilities and programs to close the manpower shortages in the health professions within seven years.

THE NATION'S financially beleaguered medical schools would receive $11,500 for the full-term cost of training each student, an action long urged by the American Medical Association. Saying that the measure was "long overdue," Congressman Paul Rogers (D., Fla.), chairman of the Subcommittee on

Continued

health, predicts that the legislation will not only solve the shortage of health personnel by 1978, but will provide the necessary groundwork needed if Congress should approve some form of national health insurance.

UNDER THE LEGISLATION, expected to pass the house in substantially the same form, each school would receive $2,500 per student per year for the first three years of training. The grant rises to $4,000 for the final year. In order to encourage swifter training, three-year schools would receive the same total as four-year schools, but the final year figure would be $6,500.

EACH SCHOOL MUST enroll an additional five per cent of students, or 10, whichever is the greater, to qualify for assistance. An extra $1,000 will be awarded schools for each student exceeding this total. The measure will also help establish at least five new medical colleges.

ADDITIONAL authorizations would provide $270 million for health manpower initiative awards to establish health education centers, and $412 million for special project grants for programs in family medicine, physician assistant training and others. The bill continues support for scholarship and student loans at increased levels.

IRS SURVEY REVEALS 83% REPORT CORRECTLY

AN INTERNAL REVENUE Service survey of 8,400 health care providers who participated during 1968 in Medicare and Medicaid, including physicians and dentists, revealed that 83% reported their receipts correctly.

FIFTEEN PER CENT of all taxpayers in the study under-reported receipts by an average of $7,700, according to the IRS, and two per cent over-reported, by an average of $16,000.

THE SURVEY was based in the main on providers of care who as individuals received $25,000 or more from federal programs. Some 15,000 providers were involved in the study, however the 8,400 studied in detail were selected by a "scientific sampling process," the IRS said.

FORTY SEVEN CASES have been referred to the intelligence division for preliminary or full scale tax fraud investigation. However, the IRS spokesman pointed out that these results do not necessarily hold true for the entire health care profession.

JUSTICE DEPARTMENT PROPOSES RECLASSIFICATION

THE JUSTICE DEPARTMENT has cracked down on the widespread abuse of "pep pills" by proposing the reclassification of amphetamines and methamphetamines so as to require that they fall in the category of non-refillable prescriptions.

THE ACTION would regulate amphetamines and methamphetamines as narcotic substances such as morphine, codeine, and opium as they carry a potential for "severe psychological dependence" with "serious danger" to abusers.

MANUFACTURING QUOTAS geared to estimated legitimate use and the filing by manufacturers of order forms would be required. However, at least one major manufacturer has endorsed the proposal.

SOME LAWMAKERS have complained that Justice did not go far enough and that the order should have included phenmetrazine (Preludin) and methylphenidate (Ritalin).

AMA ENDORSES DUVAL APPOINTMENT

COMMENTING on the appointment of Merlin K. Duval, M.D., by President Nixon as Assistant Secretary of Health and Scientific Affairs, Department of Health, Education, and Welfare, American Medical Association President Walter Bornemeier, M.D., said the AMA "enthusiastically endorses" the selection.

DEAN OF THE University of Arizona College of Medicine and former professor of surgery, Dr. Duval, 48, succeeds Roger Egeberg M.D., who remains as a consultant on health at the White House and as a special assistant to the HEW Secretary.

DR. DUVAL is a member of the AMA's Committee on Undergraduate Medical Education and the Liason Committee on Medical Education. A graduate of Dartmouth College and Cornell University Medical School (1946), he is a board certified surgeon.

"CANCER CURE" PROGRAM DIRECTOR TO REPORT DIRECTLY TO PRESIDENT

PRESIDENT NIXON recently signed into law a $6.9 billion supplemental appropriation bill containing an additional $100 million for cancer research. The "cancer cure" program would have an independently budgeted research unit within the National Institute of Health with a director reporting directly to the President.

"AS I HAVE SAID before the time has come in America when the same kind of concentrated effort that split the atom and took man to the moon should be turned toward conquering this dread disease," Nixon said in a statement.

ELLIOT RICHARDSON, Secretary of Health, Education, and Welfare, commenting on the President's action remarked:

"I MIGHT just say briefly that what has been recognized here is the need for and the opportunity for a degree of the kind of managerial focus that has been effective in marshaling resources in other fields."

"THERE IS a distinction, of course, as the President pointed out in his health message and elsewhere, between this situation and the moon shot in the sense that there is a need and an opportunity for the development of new knowledge. But at the same time . . . there is an opportunity also for the exercise of a central directive authority particularly in those aspects of the work that can be targeted and handled by contract, rather than grants with individual scientists."

SS COMMISSIONER ROBERT BALL COMMENTS

SOCIAL SECURITY Commissioner Robert Ball in a recent address on the concept of Health Maintenance Organizations listed six conditions that he considered essential to their success. The first condition, in Mr. Ball's estimation, was that

Concluded

"this way of practicing medicine must be made attractive to large numbers of physicians."

IN ELABORATING on this point, Mr. Ball said:

"SUCCESSFUL ORGANIZATIONS of any kind depend upon high staff morale. Thus, no health care system will work well that is not reasonably satisfactory to the key profession in that system. Physicians must be attracted to health maintenance organizations and they must feel good about what they are doing. High physician morale is by no means solely a matter of adequate compensation, although adequate compensation is important. The physician must be convinced of his ability to practice good medicine and to be generally free of bureaucratic constraint on professional judgment. Incidentally, it seems strange to me that the matter of physicians' likes and dislikes are so frequently overlooked by health care planners. We worry a lot about the morale of the armed forces, of school teachers and other government employees; in the health care system we better worry about the morale of the providers of care." ◀

New Materials on Hypertension Issued by Heart Association

"Mechanisms of Hypertension, 1970," the proceedings of two-day scientific sessions held by the American Heart Association's Council for High Blood Pressure Research, are now available in book form.

Issued as Volume 18 in the Hypertension Series, the book deals with medical problems related to hypertension and will be of special interest to physicians and researchers in the hypertension field, as well as internists, cardiologists, medical libraries and medical schools.

Earlier volumes in the series dating from 1961 onward are available from the AHA National Office at reduced prices.

Also in this area, a table-top "Diagnostic Testing Unit on Hypertensive Disease" has been prepared by the Heart Association for use at medical meetings, as a teaching exercise for medical students and house officers, and as a basis for discussion at hospital staff meetings.

The unit's four panels illustrate pertinent laboratory data on four patients. After reading their case histories and studying the panel's x-rays, eyegrounds and electrocardiograms, the physician fills out a multiple choice questionnaire concerning each case. An accompanying 14-page booklet contains instructions for testing, case histories and questions and answers.

The 10-pound unit may be obtained on a loan or purchase basis from local Heart Associations or the AHA Central Office, 44 E. 23rd St., New York, N.Y. 10010.

Art, Hobby Show Planned For ISMA Annual Meeting

Space will be provided at the 1971 annual meeting of the Indiana State Medical Association, October 12, 13 and 14, at Indianapolis for a Physicians' Art and Hobby Show.

The Woman's Auxiliary of the Indiana State Medical Association has been invited to participate in the show.

Members of ISMA interested in exhibiting pieces and requiring any information regarding this can contact:

Indiana State Medical Association
3935 North Meridian Street
Indianapolis, Indiana 46208

It will be the responsibility of each physician to see that his work gets to the exhibition at the Murat Temple, Indianapolis. Final arrangements will be taken care of by a committee.

The ISMA will provide suitable display facilities, but each physician is responsible for transportation costs and any other such expenses involved in entering his exhibit.

We solicit your exhibit to make this the largest and best ever this year.

Application for Space in Art and Hobby Show Exhibit

Mail to:

Indiana State Medical Association

3935 North Meridian Street

Indianapolis, Indiana 46208

Name_____

Address_____

City_____

Type and number of pieces to be displayed: _____

Photography_____

Sculpture_____

Crafts_____

Painting_____

Other_____

Estimated amount of space required—lineal or square feet _____

Other information_____

_____

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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Volume 64 — July 1971 — Number 7

A Horse-and-Buggy Doctor in Hoosierland

ELISABETH ZULAUF KELEMEN

Norfolk, Conn.

THE high point of my childhood was a visit to the home of my grandparents, Dr. and Mrs. William D. Hutchings, in Madison. The spring wagon, loaded with the trunks, started off early from our home above Jeffersonville, and we followed in the surrey, brakes screeching painfully as our old roan horse Rex was maneuvered down the steep levee and onto the ferry to Louisville.

The regal mail-boat "City of Louisville," wearing crowns on her two slender smokestacks, lay at the cobblestone quay, loading crates and boxes and serene, well-dressed passengers. Then the long narrow gangplanks were hoisted and she swung out into midstream with all the aplomb of an ocean liner. A mile or so upriver we passed our own house on the Indiana side and the maids waved white tablecloths from the roof of the porch. Dinner on the boat was lavish. The great table wore a little metal collar around the edge to keep the dishes from walking off. Everything clattered and tinkled in the exciting throb of the twin engines. A silver mushroom secured by a silver collar and slim chain corked the heavy glass water-bottle. Afterwards we were put down to rest on the narrow hard bunk in the narrow soap-smelling stateroom. The shutter was closed over the little window and, in spite of vociferous protests, we usually fell asleep.

At Madison, a cluster of Hutchings aunts stood on the dock. Another spring wagon awaited our baggage and my sister, who was "delicate," rode up with the driver, to my envy. The rest of us walked—I think it was up Broadway—though that seems somewhat out of the way. And when we passed the fountain—hoary then and neglected—I entered an enchanted world.

Dr. Hutchings moved his family from Vine Street to the "big house" at 120 West Third sometime in the early 1880s. The property ran through to Church Street, with stable and wagon shed at the back. It was a patrician building of white brick. The stone lintel on the kitchen door was carved with a worn date, the last digit illegible: 1840 or '48. The main house seemed somewhat later in construction. Inside was a series of spacious rooms, each extending the width of the building and opening on a broad two-story wooden gallery on the garden side, shuttered against the weather—a wonderful place to play on rainy days. There was a cavernous cellar and a huge attic. Many things from this house that were put away and forgotten furnish the core of the Memorial Museum today.

The small unpainted brick house that stood across the brick areaway constituted the doctor's office and dispensary. It was considerably older than the dwelling and had served as a law office before the doctor bought it. A letter from Grandmother to her elder daughters, at school in Cincinnati, tells of the change.

"June 2, 1882

Dear Children:

Just received Maude's letter stating that you will be home Wednesday. . . . I send you this clipped from the "Star," it explains itself. Bring it home with you as I want to keep it. I was foolish enough to feel real bad because you found out about the change which I wanted to be a

complete surprise. Your father's office being changed will gain us more room and Papa will not be annoyed with the crying of children. Papa says you may have new furniture for the Parlor and Curtains, which I will wait until you come home to select. We intended to build this summer, make the back building two-story but gave it up for the present. You will receive by this mail a chk for $40.00 and Miss N. bill for $23.50 for sheet music which your Papa says pay and bring home receipt. Then if you have enough money to get a Piano Cover select one and bring home. I hope you will have enough to buy a nice large-print edition of Shakespeare that your Papa wishes and if the money holds out the books, at Secondhand store all of them (Shakespeare also). Mr. Ham talked of 'Frank,' 'Desert Home,' 'Little Women' . . . ."

Infirmary in Doctor's Home

As regards the separate office building, family tradition has it also that the doctor was continuously bringing patients into the big house who were either too ill to be permitted to return to their homes or whose homes were inadequate for their care, and that Grandmother complained that her children were catching too many of the various ailments they brought in. The two large rooms downstairs in the office served as waiting-room and surgery, and the two corresponding ones upstairs as a sort of doctor's hospital. (The King's Daughters' Hospital was not established until 1899, my grandmother and Aunt Maude Hutchings being founding members.)

My own memories of my grandfather are vague. I have the impression of a tall, rather stern personality whose word was law. He vaccinated me for smallpox when I was three. I remember that he was sitting in the front room of the office, by a little table. He grasped me firmly by the upper arm and began scratching at the skin with a little knife. I protested and when he persisted I twisted round and kicked him. I remember his laughing softly—which only added to my rage and frustration. He died the following year. His history comes down to me only through family traditions and the material that was preserved in the old house and was revealed when that was sold and the attic cleared for new tenants in 1938.

Of Scottish Descent

William Davies Hutchings was born on September 15, 1825, at Lexington, Ky. (he died April 2, 1903, in Madison). In mid-18th century a Hutchings ancestor had set sail from Scotland for Boston with his two motherless sons, William and Oscar. He became ill and died on shipboard and was buried at sea. The ship's captain undertook to place the two orphaned boys; William was apprenticed to a confectioner, Oscar elsewhere. Neither was happy (who knows the details of such a life in 18th century New England?) and Oscar soon ran away. But William persisted and served out his apprenticeship. He took part in the Revolutionary War and apparently took out land as his soldier's bounty and moved to Kentucky.

My grandfather, who bore his father's and grandfather's name, was probably the first-born son. He had an older sister Agnes who died early and at least one brother, Homer. (A poem of hers exists, published in a Louisville newspaper in 1845.)

From the age of six, William wished to be a doctor. While studying at the Academy in Lexington, he with other young medicos worked with the victims of a yellow fever epidemic that struck settlements at the mouth of the Kentucky River in 1849. It was there he made the observation that the epidemic raged as long as the weather remained heavily overcast, muggy and windless, and that after a terrific thunderstorm with high winds no new cases developed and the sick folk gradually convalesced. This led him to conclude that the electricity of the storm had dispelled the plague. The efficacy and importance of electricity remained one of his hobbies. Convinced that its progress would revolutionize life, he made a note that he felt his best on a river trip, "because of the increased electricity" in the air. For some types of therapy, he bought a

News Item from the Madison Star, June 1882

"Dr. W. D. Hutchings moved into his new office on Third Street today, and has it very neatly and conveniently fixed up and arranged. It was formerly the law office of the late Michael G. Bright and afterward of Judge Cravens. The transition has been from a legal grist mill to a pharmaceutical dispensary for the alleviation of bodily infirmities."



THE office of Dr. William Davies Hutchings, Madison, which is being restored by Historic Madison, Inc. Much of the equipment used by the physician will be on display and the furnishings of the office and two upstairs bedrooms used as a "hospital" are intact.

complicated electrical "rejuvenator" which is part of the museum collection.

Medical diplomas are at hand from the Indiana Central Medical College, Medical Department of Asbury University (now DePauw University), Greencastle, class of 1851, a department in existence between 1850 and 1854. Also from the college of Medicine of Ohio, a diploma to W. D. Hutchings "In Doctoris in Medicina, Gratum, 1873."

An idea of the cost of such an education can be had from a letter from his brother-in-law, Robert Koehler, whom he helped put through a medical education at Ann Arbor:

"March 4, 1866

Dear Doctor,

I received yesterday by express fifty dollars from you and was exceedingly glad to get it as I had been out of funds . . . I will have sufficient now to see me to the close of the term which will be two weeks from now. I had hoped at the beginning of the session to go through for about $175, but my expenses at the college exceeded my anticipation. For matriculation and incidental expenses I paid $25, for dissecting $15.00, for "Ford's Quiz" and skelleton $9.00 making $49, and my traveling expenses will be $35. making $84—leaving me $116. My board and lodging and lights cost me $4 a week —making just one hundred dollars. With the next two weeks you can see what I economized very well. . . .

Business at the University goes on as usual—only as is generally the case toward the close, there is not so much energy on the part of the faculty and most of the students as in the earlier part of the session. . . . Professor Gunn is still as interesting as ever in his department of Surgery —and our clinics are very good indeed. I wish you could see him, you would like him I know. He demonstrates all fractures, dislocations, etc. on a dead subject. And has been ligating all the artieries on a subject. He is now lecturing on the eye. . ."

Practiced in Wooster

As a young doctor, William Hutchings practiced in Wooster, Scott County, possibly in conjunction with a Dr. Woollen, an older man who is mentioned cordially in a number of family letters and remained a lifelong friend.

"Woostertown," always a tiny settlement, has long disappeared from the map. One wonders how and where the doctor lived, serving quite a stretch of the countryside. He drove a beautiful buggy—a status symbol is those days. The town bully, who had already run one young physician out of town, seared one of its varnished red wheels with a hot poker, and the doctor's usually carefully restrained temper flared. He laid his gloves, handkerchief and wallet in his hat beside the medicine bag, leaped out and fell on the man, beating the fellow's head on the ground. He confessed later that if he had not been pulled off by bystanders, he feared he might have killed him. From that time, the new doctor went unmolested.

It was in Wooster that Dr. Hutchings met his future wife. Matilda Christine Koehler, born April 25, 1840, in Springfield, Ohio, was 15 years younger than Dr. Hutchings. Her grandfather, a doctor, had migrated with his family from the kingdom of Wurtemburg (Germany), landing in Baltimore in 1819, according to her father's memoirs of the journey which was made as a 11-year old boy. Matilda's father, Adolf, lived for a time in Springfield, Ohio, and married the daughter of a Bremen merchant who had settled in New Orleans. Restless, not too successful as farmer and storekeper, he drifted with his growing family into southern Indiana.

In her mid-teens Tillie, as she was called, attended the Frederick Female Seminary, in Frederick, Maryland, living with an uncle there. Back home at the age of 17, she opened a school with an older sister. The handwritten contract reads:

This article of agreement made and entered into this day of December/57 between Mary Van Pelt and Matilda Koehler of the first part and the undersigned subscribers of the second part, witnesseth—

The parties of the first part agree to teach a school in the town of Wooster one quarter or thirteen weeks and teach the following branches

Reading, Writing, Authography, Geography, Arithmetic, English-Grammar, Philosophy, dictionary, exercises in Catechism, History and Composition. They agree to teach in the school house and furnish their own fuel. —The parties of the second part agree to pay two dollars per quarter for each scholar, they (the scholars) conforming to all the rules of the school. And the subscribers will furnish all that is necessary for their children.

Any scholar who cannot by kind treatment be induced to conform to the rules of the school will be reported to their parents or Guardians after which if they continue refractory expelled the school and held liable for the tuition.

Seventeen children were registered.

It should be realized that in the mid-1800s. Ohio, Kentucky and Indiana were Far West. A woman's only possible employments were teaching and sewing or millinery. The Female Medical College opened in Philadelphia in 1850; Vassar College was founded in 1865; a professional school for nurses, in 1873.

A daguerreotype of Matilda at around 17 shows a radiant, romantic, impulsive girl. She and a friend must have sent Dr. Hutchings some apples in token of admiration. His carefully dignified reply is at hand on one of those bits of blue paper so characteristic of the "notes" of that day.

folded to the size of a commemorative postage stamp, and addressed to Tillie and Celia:

"Young Ladies

I accept with many thanks your agreeable present. You must have wandered into the gardens of Pomona in your romantic 'ramble' and had the assistance of the goddess herself in gathering the ripe and blushing fruits with which you have complimented me. Flora too must have contributed to the offering as emblematic of olden times when the goddesses and Nymphs were in sweet communion.

With profound sentiments of regards, believe me

Your

Will."

The classical reference as well as the handwriting identify him. He liked to append an apt Latin motto to his medical articles and his infrequent but cogent letters to newspapers. His oldest daughter reports that when he was old and ill, he could recall only the Latin names of his drugs.

Matilda C. Koehler and William D. Hutchings were married in the fall of 1861, and shortly after moved to Lexington, Ind.

Life during the Civil War was far from easy, even in such a small community. The churches were split into factions over the war. Tillie reports so much illness that the doctor was away many nights, though ill himself.

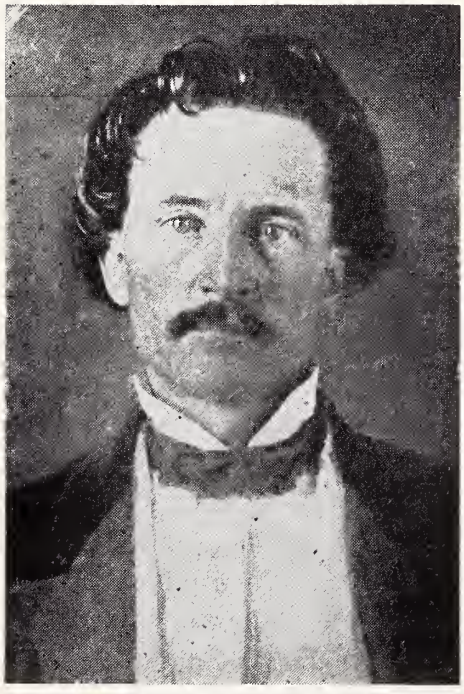
"Here we are perfectly *mud-bound*. The buggy could not come when it was so bad and when the weather was fine, the doctor had no time.

"I am miserably lonely tonight, for Doctor is in Indianapolis at a convention (he is a delegate). Since he is gone they have been coming for him. I have a list of names and the cry of each is 'Please tell him to come *as soon* as he is home.' Doctor had Charlie C—to come up at night, so I am not alone. You should see the desperate weapons ranged beside my bed for any emergency—make ready, aim, fire!"

A staunch Union man, though a Democrat, the doctor served two terms in the Indiana General Assembly, which partly accounts for the many law tomes in his library. At the time of the above letter, however, he refused nomination because of ill health and the pressure of his practice.

Prices rose steadily during and after the war. The doctor sold his much-prized buggy. Tradition has it that when Morgan's raiders passed through Lexington (1863) Matilda led the doctor's only horse into the tall corn and hid there until all was safe.

The doctor is mentioned as a Master Mason in 1868. In 1869, he was re-elected to the legislature. In 1875, already with six children, the family moved to a house on Vine Street in Madison—which was still a prosperous river port, though its greatest prosperity had passed with the war. From there, five or six years later, they moved into the big white house on Third Street which I knew as a child. Willie (d. 1875), Maude, Josephine, Charles Frederick, Robert, Herman and Agnes (my mother) were born in Lexington; Lida and Zoe in the late '70s in Madison.



DR. HUTCHINGS was arrayed in his wedding finery when this photograph was taken in 1861. He was 36.

Most families kept a cow; Tillie mentions 2 gallons at each milking and a pound of butter a day. Summer was a whirl of putting up vegetables from the garden and, in season, the family went berrying for blackberries, elderberries, grapes for jelly. Peaches and pears were made into preserves. A "girl," usually from some nearby farm and inexperienced in the ways of a town, was hired to help with the heavy cleaning, cooking and scrubbing which the housewife supervised. All clothing was fashioned at home, at least at first. For the doctor's birthday in 1870 his wife embroidered for him a beaded watch case on scarlet velvet in the shape of a slipper.

In the Third Street house a room was set aside for the children and their games. Halloween was a time of special gaiety and elaborate costumes, designed and executed by the two older sisters.

A wonderful doll's house survives, which the Museum will show. A pony-size rocking horse that stood on the landing but took me to untold foreign lands was given away years ago.

Each older child assumed the responsibility of one of the younger ones. On one occasion, returning from making the rounds with the doctor, my grandmother found all the children sitting on the roofpole of the three-story building. My mother, a baby in arms, was among them, in Joie's charge. When questioned, they said they wanted the baby to see the view. Grandmother said quietly, "Bring her down now; it is time for her supper," and went into the house so as not to excite the children with her own alarm.

An old friend who was much at the house tells that, at dinner time, Matilda would go to the office and escort the Doctor in "so stately as to a wedding feast." Maude, the eldest daughter, would be in the dining-room to greet and seat the guests who followed host and hostess.

A zither, two violins, a guitar and

a banjo were found in the old house. Maude, Fred, Agnes and Lida played the violin, Tillie the guitar. Several played the piano adequately, by ear. Joie had a smooth alto voice; Agnes, a remarkable high soprano. She sang in church and generally took the lead in the operettas that were given in the enterprising town. Some training in Cincinnati was aspired to but that never came to pass.

Discipline was unobtrusive but firm. When Agnes, aged about 19, was entertaining a swain in the front parlor, someone passed through the back parlor and struck a single note on the old square piano there. "That is G," said Agnes rising, "it means GO. . . ." Later, visiting the younger sister of the minister's wife in Jeffersonville, she was courted by the next door neighbor. In describing the visit she mentioned going out driving with him. Her friend exclaimed "Agnes, you know your mother would never allow you to drive out alone with a man unless you were engaged"—and so the secret came out sooner than intended.

Tillie "scribbled" incessantly; while sitting with a sick child, sewing, or waiting for the doctor, she jotted down poems on the backs of old envelopes, bits of wrapping paper. Some were published in the local newspapers and in anthologies of Indiana poets. She also published a number of short stories in Hoosier dialect, but none of these have come to hand, though spoken of in several letters. Especially charming are her many Christmas poems, full of wonder and delight.

Christmas and birthdays were made much of, though at first the gifts were modest—second-hand books and colors at 10 and 25 cents, a tin horn for Willie, which he promptly traded to Joie for her little red wagon. Later, Maude reports that her mother appeared on the scene with Bibles, prayerbooks and hymnals, fairy tales and folk stories, while Father preferred to give bits of fur or jewelry, histories and essays, and there were always pictures from both.

Many Papers Stored Away

In 1967, at the request of my only surviving aunt, Lida Hutchings, my husband and I went to Madison to sort through the material which she had stored in the office. The first sight threw us into despair. The four ample rooms were literally piled to the ceiling with heterogeneous trunks, boxes, cartons, newspaper packages. Fortunately, most had been labeled—a gargantuan task in itself—when they were moved from the attic of the "big house." Resolving to keep only the early documents (up to 1905), unless later ones were of primary importance, we cleared out some five pickup truckloads of miscellaneous trash—old coffee cans, paper bags, letters, Christmas cards and invitations, newspapers, rags. We were just wishing to put the whole thing to the torch when Mr. John Windle, President of Historic Madison, appeared at the door to see us, smudged as we were with coal dust that had sifted unheeded for years through a broken windowpane. He told us that he had long been interested in the house—closed, mysterious, dilapidated—for Historic Madison, for, small as it is, it is one of the purest Greek-Revival style buildings in the city. So, the plan for the memorial museum developed, to the great satisfaction of the last Hutchings, 90 years old and far from her childhood home.

Enough remains to give an impression of the furnishings and equipment of Dr. Hutching's office and dispensary. His rolltop desk and bookcase is there, the horsehair sofa and armchairs in the waiting room. Decorations for the mantlepiece, vases and the calendar clock which Tillie mentions proudly in 1867, lamps on the marble-topped tables. Upstairs in the two bedrooms of the "hospital" are two large carved Victorian beds with rare old quilts as coverlets, a cradle, and many bookcases filled with contemporary books, both scientific works and belletristic. Numerous engravings and family photographs grace the walls—several portraits. One represents Tillie's favorite older brother, Herman Koehler, who was an excellent amateur artist and painted a number of fine watercolor landscapes hanging in the house.

The trappings of the doctor's horse are there—the saddle, the buggy harness, even the fly net for summer days; his broad-brimmed heavy felt hat and the cape, ample enough to protect the horse's croup in bad weather. An Indian-cured buffalo robe from Wisconsin now replaces the one which many years of service had worn to shreds.

Several guns are at hand, a large medical satchel and more than one folding medicine case, fitted with small, precisely marked vials. From the dispensary, a spirit lamp remains and tiny crucibles, mortar and pestle for grinding powders, a small marble slab for the mixing and rolling of pills, and several "invalid cups" for the feeding of bed-ridden patients. A piano stool stood before his desk, on which to swivel from patient to table and back.

The doctor fashioned his own splints for broken bones, inventing one that would strengthen a broken clavicle; these fit neatly into a mahogany box, also made by him. Another polished box contains his Braunscheider "Lebenswecker"—the "life-restoring" electric machine previously mentioned. After his death many of his surgical instruments went to his son Robert, a physician who practiced in Denver and San Francisco, and so are missing.

There are medical reports, various brochures on new medicines and methods, clippings from letters he wrote to newspapers discussing new treatments and discoveries. He attacked Dr. Koch's treatment of tuberculosis with "tuberculin" as dangerous because of what we now call its side effects. Although he claimed

A bill for drugs from the W. H. Rogers & Co. Pharmacy, from 1881 to 1883, for $101.77 in all, includes:

1 th cream of Tartar	45¢
1 oz Cinchonidia	75
1 pz dextro quin	
½ th Bromide Potass	25
6 oz. spts & vial	20
2 oz. Salicin	70
¼ th tartaric acid	16
Carbolic acid	25
3 oz brandy & vial	13
4 oz fine cut (tobacco)	25¢
4 " P. Rhubarba	31
violin strings	50
4 oz. Fowlers salut	10
3 grs. morphine	5
4 oz iod. Potass	80
2 " sul Manganese	20
8 oz. spts Nitre	25
20 Vaccine points	2.00

a definite cure for diphtheria by medicine, he recommended diphtheria inoculation when used with caution.

Warning Against Cholera

Upon request, he published a warning in 1873 to the general public in case "the cholera scourge now raging in the Old World invades Madison." He advised abstemiousness in eating and drinking but no radical change in lifelong habits; above all, a thorough cleaning and disinfection of cellars, stables and outhouses.

"Talk not of quarantine, as well attempt to quarantine a cyclone . . . If the worst comes, we must throw aside cowardice, man ourselves for battle and victory. For it is written in heathen Mythology that Jove sent Pestilence to the earth to destroy 5000. Jove soon learned that 10,000 had been slain and called Pestilence to account for disobedience, but Pestilence affirmed his innocence and claimed that Panic came along and destroyed the other 5000."

Dr. Hutchings kept his own records of vital statistics, ending his list of live births with the 2000th (two thousandth!). Official records were not instituted in Indiana until 1882. The maladies most frequently mentioned are Asiatic cholera, chills and fever, flux, pneumonia, the dread diphtheria, scarlet fever, small pox, typhoid and typhoid-pneumonia, whooping cough and complications.

The doctor's shingle from Lexington is still at hand, listing office hours that began at 5 a.m.

In Madison, his hours were from 7 to 8 a.m., 12-2, and at 7 p.m. His charges were low—"for a visit to Mrs. D. . . and daughter, $1.50." Even then, he did not collect from the poorer members of his practice. At his death, his daughters reckoned that unpaid bills on his books amounted to over $50,000—a fortune for the widow with four unmarried daughters. But, alas, several of Madison's most well-to-do families refused to pay when appealed to—an experience that is surely not unknown to the practitioner today.

As often, payment was made in kind. A fine leather-bound edition of Prescott's "History of the Reign of Ferdinand and Isabella the Catholic" (Boston, 1856) in three volumes is inscribed "W. D. Hutchings in payment for a surgical operation on Noah Davis." The doctor received at least four Snyder landscapes for services rendered that excellent local painter, the largest of which hung over the mantlepiece in his waiting room.

Kept Numerous Scrapbooks

An avid interest in all scientific progress is manifest in Dr. Hutchings's numerous scrapbooks covering such various subjects as historical events, exploration, biographies of contemporary great men—often generals and presidents—as well as notes of medical achievements. In a letter to the *Madison Star*, he lists the "firsts" of American doctors: first to ligate the inominate artery, first to remove ovarian tumors; and he praises American dentistry as unsurpassed anywhere.

His geological collection of fossils mainly from Indiana is now in the Indiana State Museum at Indianapolis.

He is described as not tall but lithe and slim, with startlingly blue eyes. Early letters speak of his "merry lightheartedness" and of his gay laughter; another of "being understood whether one talks sense or nonsense." Unfortunately, the few letters in his own hand that remain are from later years and contain chiefly medical advice, often mentioning the weight of cares and ill health.

"Madison. March 14, 1882.
My dear Children
(daughters in Cincinnati)
I recd yours today. I have no news for you. The family is well as usual. Am almost worn down by the labors, cares & anxieties of my professional life and sometimes would almost welcome the repose of the grave.
Find inclosed the $50.00.
Yours affectionate
Papa"

"Dec. 23, 93: If I had been a dissembler, a cheat or less kind in my dealing with my fellow men, I would now be quite wealthy, looked up to, pandered to by the ungrateful wretches whom I have benefited. My boys know nothing of the Valley of the Shadow of Death thro which their father has passed in his childhood and pray God they may never feel it. Hence my anxiety for my children's future in this life. If my cihldren are true to themselves. . . then they are true to all mankind. Now my Daughter let us look to the bright side of the picture of our lives. . . ."

A note to his wife dated March 16, 1897, affords a rare glimpse of the inner man. It is addressed in care of the Zulaufs in Jeffersonville, where Tillie was attending the birth of their first granddaughter, my sister Agnes. After a factual page of advice on the care of the young mother and the two-week old child, signed "your

devoted Hubby," he adds a penciled postscript:

"With love to Agnes and John. Tell them they can now begin to feel what their parents had to go through at a certain time.

"In crowded halls, in festive bowers,
In musings lone and tearful hours,
In every change that tosses me
With changeless love I think of thee."





THESE photos of Dr. and Mrs. Hutchings were taken in the mid-Nineties when he was in his early sixties. Matilda Koehler Hutchings was 15 years younger than her husband.

Attend Convention

Of a medical convention in Washington, Tillie writes:

"Washington City. April 6, 1887
Dear Girls— . . . .

Papa took the news of John's sickness very philosophically, in fact he has abandoned all home care and is enjoying his vacation like another school boy with Dr. Woollen. You would laugh to hear them together, such laughing and funny story-telling would surprise you. We both feel in excellent health, albeit a stiffness and soreness—you would understand if you knew the amount of walking I have done. . . .

The M.D.'s go off after breakfast to their meetings. Then Mary (Mrs. Woollen) and myself put a lunch in our handbag "grip-sacks" and sally forth. Don't be uneasy. I array myself *with care* and my bonnet and attire are quite as good as the ladies I see on the street.—We ate our lunch on the gallery outside the Capitol Dome yesterday, just to eat *higher* than anyone else. The magnificence pictured and described give you no idea scarcely of it. We are going up Washington Monument today . . . . We are going to a reception by the President—that is the M.D.'s and I think their wives. We are also to have a government boat and be taken to Mount Vernon, Washington's tomb. The Doctors are being highly honored and there are many foreign Doctors here . . . . I am so delighted to see your Papa so *young*. He is so handsome among the other gentlemen, and I am so sorry he is not prepared to read an original article. If any 'Mag' comes look if any piece of his is in it. But don't read the articles in the Magazines, they will give you impressions that will always haunt you. . . ."

There are several letters of appeal from Lexington and later:

"April the 24, 1875

Doctor Hutchsons I have been sick for four months.

I was taken with hot sensation and cold ones all through my systom. I have been doctering with a docter ever sinse but he has not done me much good. he has only give me medison for my head and pills to keep my bowls free. now I have hot flushing in my face and cold shivers threw my back and general weakness my stomach weak and my tongue coated white and ringing in my ears. I want you to send me some medison and tell me if you think you can help me write me a note. My heart is in a bad fix

Samuel Towrs

I have bad distressed feelins"

"Volga Nov. 3, 88

Dr. Hutchings

Sir I have a kind of spell from 9 to 12 every morning it seems to arise from the stomach sometimes I am chilly and wind up with fever. I don't think my cough is any better. The only improvement I notice is not throwing up my food.

Respectivly
W. Kinnear"

"Madison Ind Jan 10th 1890

Dr. Huching

Your Bill was duly received I am sorry I cannot settle it at once But will try to soon, I would of settled it sooner and saved you trouble but owing to continued sickness and dispointment of money due me it has been imposible Yours very respectfully

Mrs. Lottie C. . . ."

A letter to Dr. Hutchings's oldest son, Fred, from a companion gives an interesting insight into the doctor's character:

"January 8, 1888

You wrote of your father being shut off from society by his duties and his books. Did it ever occur to you that your father enjoys his pro-

Prescriptions for Family Use

Here are a few prescriptions apparently jotted down by Maude for family use. Any anomalies or incongruities should be laid to the difficulty of a layman in deciphering the penciled lines on old, much-folded paper. Unfortunately, the only diphtheria prescription at hand is largely illegible. Included also is an ancient prescription on parchment in the flowing hand of great-grandfather Koehler.

Chills and Fever

Quinna Sulph ℥ 1/j 1 dram
Iodide Potassium ℥ ⋯/1 40 grs
syrup ¼ pt—Whiskey ¼
Dose tablespoon before meals. Take several purgatives before commencing this.

For flux may be taken every four hours
a capsule of small dose of muriate of quinine and tiny pill blue mass. At same time take every 3-4 hours resorcin—1 rounded teaspoon in ½ glass of water, with a little glycerine added if wished.

Great-grandfather Herman Koehler's recipe for cough drops (1818):
Take 2 oz. Spikenard
Bloodroot — 1 oz — anise seed
Cabage(?) 2 oz — Liquore
1 oz — Sulphur
2 oz. Gumarabic
1 oz. Ale compane(?)
1 lb. sugar
Boil ingredients together and drain them; boil down to a syrup and then add a quart of rum to preserve it.

fession and books more than he would any society. You know he has theories of his own in regard to almost every question of the day and he don't like for anyone to have a contradictory view. I never tried to advance a theory opposite to his own but once and never expect to again. He is a man of strong likes and dislikes and to oppose him is to incur his displeasure. The very place for him is where he is and he would be miserable in other company. I admire the Doctor more than anyone I know of and would do anything for him but our tastes are a good deal alike and one does not like to mix in society more than the other. If it were not for such men as Dr. H. . . . what would we do! Long live Dr. H. but I think he is as contented as he possibly could be. . . ."

"A Remarkable Surgeon"

At Dr. Hutchings's death in 1903, the *Madison Star* wrote a highly appreciative editorial. But his daughter Maude, who was his nurse and laboratory assistant for decades, gives a more comprehensive picture in correspondence with a colleague of her father's in Pittsburgh. "In the early 60's he treated diphtheria with calomel and seldom lost a case. . . . The late Dr. Mussey of Cincinnati held that since taking up our father's method, he feared diphtheria no more than an ordinary sore throat. Prior to 1870 Dr. Hutchings originated a formula of drugs for the treatment of tuberculosis, having expressed the belief that this ailment was preventable and curable, a treatment so effective that it was used up to the time of his death. In 1882 he added to the treatment hypodermic injections of carbolic acid and atropin and was able to save cases otherwise not to be reached by internal medicine alone. He discovered a disinfectant solution for wounds that was so efficacious that healing 'by first intention' was the usual result. In 1878, he discovered a specific for yellow fever and made a spectacular cure (of a riverboat captain who had arrived from New Orleans with the disease). In '79 the doctor made the first recorded cure of exophthalmic goitre and, during the influenza epidemic (1890 or '92), lost not a single patient though many were more than 70 years old and some over 80. A member of the Board of Health told the family that he had experienced several epidemics of scarlet fever and pneumonia during his service and that Dr. Hutchings had had as many patients as the other physicians in the regions but seldom a death to report.

"Our father was a remarkable surgeon. He was the first doctor to remove a dead bone and leave the periosteum to make another. A two-year old child from Scott County was the patient. A portion of the bone in his upper arm had died. The bone was cut just above the elbow and below the shoulder. The family moved away a short time after the operation and Dr. Hutchings had no report of the result. But years later an old woman who used to live at the tollgate on the other side of Hanover saw the doctor pass, stopped him and recalled herself to his mind, mighty proud of having been his nurse on that occasion. She said the muscles had grown and attached themselves to the shoulder, a new bone was secreted and the patient recovered the full use of his arm. The child's name was Hayes—and he was one of the lawyers in the notorious Pearl Bryan murder trial. . . ."

Maude ends her letter: "He seldom spoke of his achievements and seldom wrote an article—he was too busy. These quiet hardworking doctors with large country clientele are many of them entirely unknown to fame forever."

Thanks to his daughters' habit of preserving what their adored father left, the Dr. Hutchings Museum should stand as a memorial not only to him but to the many valiant and ingenious, if nameless, horse-and-buggy doctors of that epic period. ◄

Acute Epidemic Myalgia (Bornholm's Disease)

HAROLD E. STADLER, M.D.

*Indianapolis**

A six-year-old male developed fever (40.0 C) accompanied by violent muscle pains on March 14, 1970. The sharp pains were generalized but were particularly marked throughout the chest. Physical findings were minimal except for muscle tenderness. He was treated with oxytetracycline, 125 mg every six hours, and improved slowly. Afebrility was established on the fourth day and the body aches were essentially resolved. Physical findings continued to be minimal with scattered rhonchi at both pulmonary bases. There was no percussion change and no suppression or even diminution of the breath sounds. On the twentieth day following the acute onset, the patient appeared to develop sudden pallor, generalized weakness and profound anorexia.

The past medical history was significant in the fact that the patient had been observed since early infancy because of a febrile convulsive disorder. During December 1965, an extensive neurological evaluation was carried out with totally negative findings.

The other members of this patient's family remained well during his illness.

The patient was hospitalized on April 2, 1970, at which time he showed severe pallor of the skin with a moderate degree of dehydration. Upper respiratory infection was lacking and pulmonary findings were unchanged.

The hbg was 10.1 grams, hematocrit 30, RBC 3.74 M, WBC 17,200 with 1 band, 80 neutrophiles, 18 lymphocytes and 1 monocyte in the differential. The routine urinalysis was negative. X-ray of the chest was compatible with extensive basilar pneumonia or fluid. ◄



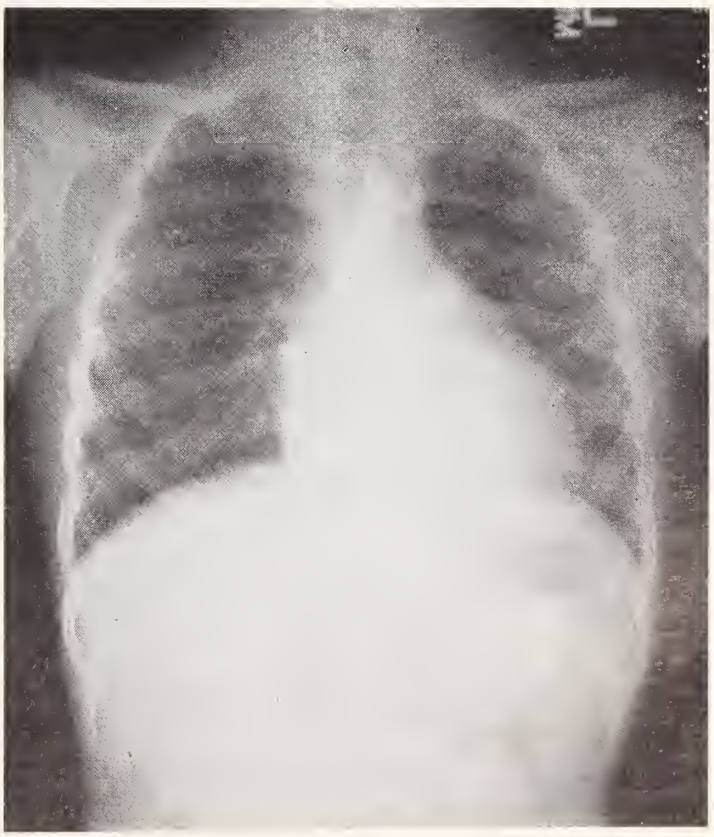


FIGURE I

THE minimal physical findings in the lung and the rapid improvement in the child (I.V. fluids) led the examiner to doubt the presence of consolidation or fluid in the lung. The child remained afebrile and within hours had regained his appetite. Penicillin was given intramuscularly in the amount of 600,000 U every 12 hours. On the fourth day of hospitalization, another chest x-ray was obtained.

FIGURE II

IT appears likely that serofibrinous pleurisy was the complication and the dramatic recovery was spontaneous.

* From the Departments of Pediatrics and Radiology, The Community Hospital, 1600 N. Ritter Ave., Indianapolis 46219.

Respiratory therapy is a comprehensive term which includes the services ordinarily referred to as inhalation therapy, as well as other techniques.

Respiratory Therapy—What Does It Offer?

JAMES L. HOBGOOD, M.D.

*Evansville**

THE respiratory therapy department of the modern hospital should be prepared to provide comprehensive care to all patients with breathing problems, regardless of whether the patient is in the hospital or is an outpatient. The emphasis in medical therapy today, especially with regard to respiratory problems, tends to be centered around the dramatic environment of the hospital, to the exclusion of effective outpatient or home care. This emphasis tends to be accented by the role the anesthesiologist plays in the direction of respiratory therapy operations.

This discussion will consider both the in-hospital care of the patient with the respiratory problem as well as the out-patient. The rising cost of in-hospital care, the explosive increase in the number of patients with respiratory problems, and the fact that these patients require a good deal of specialized care should provide ample stimulus to the development of community medical services that provide qualified respiratory therapy to meet these needs.

The respiratory therapy department should be under the full-time direction of the most expert, interested physician available, irrespective of the primary discipline he represents. It is imperative that he remain in free communication with representatives of all concerned disciplines, so that he can be made aware of their needs, and they, in turn, can be made aware of his recommendations.

The responsibility of the director cannot be met by the individual physician whose patient is being treated, because he cannot supervise the selection of equipment and personnel. The individual physician cannot be expected to supervise the training and the performance of the technicians and therapists in regard to execution of the requested procedures and the care and maintenance of equipment.

There are four main categories of functions and they are included in the functions of the respiratory therapy department:

1. Patient diagnostic or treatment services.
2. Technical and medical consultative services.
3. Pulmonary function evaluation with respect to assessment of the effectiveness of treatment.
4. Training of physicians and nursing personnel.

The patient's services are:

1. Gas therapy.
2. Aerosol therapy.
3. Ventilatory assistance or resuscitative therapy.
4. Special patient diagnostic and observation services.
5. Respiratory therapy department.

In other areas, and in the future, other services may be added. The well qualified respiratory therapist should be able to provide and supervise all these functions.

Gas Therapy

Gas therapy consists largely of oxygen therapy which should be carefully controlled to meet the patient's physiological needs. At the same time the potential dangers of excess oxygen should be heeded. The therapist must assess the situation in any given case, not only from the standpoint of pulmonary gas exchange capabilities, but also metabolic oxygen requirements, available hemoglobin and cardiac output. In certain situations mixtures of other gases with oxygen, such as helium, are indicated in certain special forms of airway obstruction where a turbulence of air flow is a major factor in the obstructive disorder, such as would be the case in tracheal or glottic stenosis. This extensive form of therapy is hardly justified in ordinary chronic obstructive disease, except perhaps in extreme cases. Other gases may appear on the scene for special therapeutic purposes. As an

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example, high density gases may be used to enhance the cough mechanism by increasing turbulent air flow.

Aerosol therapy has a spectrum ranging from very small volumes to high volumes of substances which range from highly potent to very bland substances. Bronchodilator agents are an example of highly potent substances which should be administered as very fine, dilute, stable aerosols. Mucolytic agents such as Acetylcysteine, antibiotics such as Polymixin and steroids are occasionally indicated. Bland solutions, such as saline and Propylene Glycol, are surface active agents which may be administered in a broad range of particle size to produce evacuation and to produce an evacuant action for mobilizing secretions or exudate from the bronchial tree. Heated jet generators or high output ultrasonic nebulizers are also used for this purpose. Since retained bronchial secretions with airway obstruction of varying degrees is such an important problem, especially with the prevalence of chronic obstructive bronchopulmonary disease, these methods should be generously applied. Failure to pursue bronchial evacuation procedures vigorously is a common deficiency in clinical practice.

Ventilatory assistance for the administration of these agents is indicated in the presence of severe ventilatory insufficiency or copious obstructing secretions where aerosol therapy cannot be expected to be effective without mechanical assistance. Conventional intermittent positive pressure breathing devices are quite similar basic instruments, and thorough understanding of the principles permits the use of any of the available devices to achieve most of the objectives related to breathing assistance. An especially important indication for the use of IPPB devices occurs in a situation such as acute pulmonary edema or in patients sedated, or inactive, as a prophylactic measure against atelectasis to promote deep breathing.

Cardiopulmonary resuscitation requires the capable assistance of the qualified respiratory therapy team. The recognized respiratory therapist should be able, in emergency situations, to perform endotracheal intubation and to provide manual ventilation with a bag system and also to provide manual cardiac resuscitation. Cardiopulmonary function evaluation is an integral part of the management of the critically ill patient with cardiorespiratory failure. Therefore, the qualified respiratory therapist should be able to take and to monitor electrocardiograms, to monitor expired carbon dioxide by an infra red analyzer and to estimate alveolar carbon dioxide by a rebreathing method. She should also be able to measure minute ventilation and tidal volume by a variety of methods. In the community hospital the respiratory therapy department will usually be required to provide certain pulmonary function studies such as the broncho-sphygmometry examinations, arterial blood and expired gas analysis. Under these circumstances the respiratory therapist must double as a pulmonary function technologist.

Sputum Examination

Certain special diagnostic services should be available through the respiratory therapy department. One of the most important of these is sputum specimen collection. This may be done for examination of sputum for tumor cells or infectious agents. These procedures involve high density, aerosol sputum production techniques. It may also involve tracheal instillation and aspiration techniques. A problem requiring special attention is obtaining a good sputum specimen without upper airway contamination for routine bacterial culturing. This involves the therapist in getting the patient's mouth and throat clean and depends upon his knowledge of what constitutes a good sputum specimen.

Another particularly important procedure in the patient with the endotracheal or tracheostomy tube is the collection and microscopic examination of tracheobronchial secretions for pus cells and for bacteria. This sort of information will provide 12 to 24 hours warning of impending infection of the lungs. Respiratory physiotherapy involves a number of special procedures for which the respiratory therapist should be particularly well qualified. The success of these procedures in many instances depends upon the personality of the therapist and his ability to communicate effectively with the patient. Most of these procedures involve considerable explanation and instruction of the patient and in many cases the stimulation of the patient's motivation. Chest percussion and segmental postural drainage either by hand or by various mechanical percussive devices are the most widely utilized procedures.

Breathing control training at rest and during exercise is vital for the large numbers of patients with chronic obstructive pulmonary disease. This involves correction of the disordered breathing patterns with emphasis on slow relaxed breathing to improve the efficiency of ventilation and to diminish the work of breathing. Deep breathing exercises are differentiated from breathing controlled training since deep breathing exercises are designed to correct problems that compromise local ventilation such as obtain after pneumonia, atelectasis, thoracotomies or chest trauma.

The respiratory therapist should be reasonably qualified in the techniques of physical rehabilitation, including graded exercises, in order that the specific recommendation of the physical therapist may be properly carried out where specific muscle group therapy is under way, in conjunction

with other respiratory therapy. The respiratory therapist should be uniquely well qualified to conduct or assist in general body building exercises where respiratory therapy, such as oxygen or ventilatory assistance, may be combined with general exercise programs. The respiratory therapy department needs to maintain liaison with other disciplines such as nursing, occupational therapy, microbiology, psychology and vocational rehabilitation, in order that a balanced approach may be taken toward the patient's total problem.

The respiratory therapy department must consult with physicians and nurses and advise them in regard to specific situations. Not all practicing physicians and nurses can be expected to be expert in the intricacies of respiratory therapy. Since professional consultation with a physician respiratory therapy specialist may not be feasible in every case, the paraprofessional respiratory therapist should be provided with limited advisory functions under the supervision of his physician medical director. Major consultation should be available in the form of a physician or physicians who are experts in all phases of respiratory therapy and who are involved in the policies and functions of the department.

Training Must Continue

The department should be engaged in an ongoing training program not only for the continuing education of the paraprofessional staff at all levels, but also to keep the physicians and nurses informed of developments in the field and adjustments in policy in the department. It is essential that the medical and administrative organizations of the hospital and the community provide the opportunity to accomplish these objectives through frequent contact with both local and outside authorities on respiratory care.

The local medical organizations also have the responsibility to establish for the community guidelines and policies for the operation and regulation of this phase of paramedical service. The alternative is that ill-informed political agencies may step in and invoke policies that may not be desirable to the medical profession, nor necessarily in the best interest of the patients.

The problems of most patients with respiratory disorders do not end when they leave the hospital. Therefore, there is need for developing many of the same kind of services for outpatients. This situation amplifies the need for establishing regulatory policies to provide assurance that the technicians and therapists who provide these services are under adequate supervision and that their practices are ethical and of a high quality. This requires independent medical supervision and essentially the same type of quality control as is exercised in the hospital organization.

Respiratory therapy is a new and rapidly growing concept in medical therapy. It is an outgrowth of the rapid growth and knowledge and the understanding of respiratory problems and the increase in breathing disorders in the general population. The responsibilities of the respiratory therapy department are such that a separate organizational structure under a medical supervisor must be provided, in order that these responsibilities be met.

Respiratory therapists must be mature, well trained individuals who are capable of dealing effectively with the many facets of total respiratory care. The medical community has a responsibility to provide a receptive climate for continuing education of all persons concerned with the functions of the respiratory therapy department both in and out of the hospital. ◀

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Some Perspectives in Biomedical Engineering and Artificial Organs*

S. D. MOULOPOULOS, M.D.**

W. J. KOLFF, M.D.†

SINCE it would be unwise to make a specific program for a period longer than ten years, let us consider what may be the most probable advances in the field of biomedical engineering in the near future.

Three main fields exist, in which contributions are predictable: (A) instrument construction, (B) artificial organs or components for replacement of diseased parts of the human body, and (C) the study of the human systems for a more objective and thorough understanding of their construction and function. Progress in the first field may aid mainly the diagnosis, while in the second, treatment will be helped. Progress in systems investigations will probably help both procedures indirectly.

For illustration, a few examples will be given of what is apt to be accomplished in each group.

(A) *In the instrument field,* we are in need of a reliable device for measuring flow, especially if this could be mounted on a catheter for intravascular use. Measurement of arterial and venous pressure, without puncturing the vessel, is becoming important for the continuous monitoring in intensive care units. It should be possible to construct the proper primary sensors.

The diagnosis of atherosclerosis is another example of future possible exploration. If we can detect particles in outer space, it should be possible to detect damage in the arteries within the body. Rushmer is already busy adapting ultrasonic devices for the purpose.

A neglected diagnostic field is the one including the skin and its diseases. It is probably the most striking example of the medical profession's indifference to contemporary technology. Dermatology is still relying on eye and sense of touch to examine an organ that is easily accessible for objective, quantitative measurement of its mechanical properties.

(B) *In the artificial organs field,* one may envision the day in which the four main systems dealing with circulating the blood and processing its ingredients, namely, the heart, the lungs, the kidneys, and the liver will be replaced en block by a single unit including a pump, an oxygenator, hemodialyzer, and a chemical processing device. Actually the first three artificial organs now available in crude form could be incorporated in one block. This would facilitate the insertion of an artificial heart and eliminate its pulmonary circulatory problems. If the four-organ system could be "fed" by processed food materials (i.e., intravenously), the digestive tract would be indirectly replaced. Since the endocrine gland function is already replaced by giving hormones, only the brain and the reproductive organs will remain irreplacable.

The combination of a hemodialyzer and an oxygenator can replace most of the functions of the placenta. The time is near that babies now suffocating with hyaline membrane disease will be sustained with an artificial placenta until their lungs recover. Examples of relatively minor projects in this field will be: the replacement of heart valves without opening the chest (by valves mounted on catheters to correct regurgitation) and closed-chest valvulotomy using small knives also mounted on catheters to correct stenosis.

It has been demonstrated that perfusion of the coronary arteries with arterial blood improves cardiac function in animals in cardiogenic shock. A small pump implanted between

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the aorta and the coronary arteries might do just that.

It should be predicted, however, that organ replacement may not be physiologically successful, if the mechanical-biochemical aspect of the system's function is not better understood.

The artificial kidney, which opened the era of artificial organs, unquestionably prolongs most of the patients' lives. It does not, however, restore them to complete health and it may not do so until the function of the natural kidney is better understood and until the artificial kidney is able to remove all the substances responsible for uremia and can be applied continuously rather than intermittently.

Surgeons have said that the main difficulty in the artificial heart project is the blood material interface. One of us believes that when this problem will be solved, the patients with artificial hearts may still die of what one could call "the artificial heart syndrome," unless we learn to understand better the heart function in relation to the peripheral vascular system. The surgical and the physiological approaches to these problems are different, and they should be integrated.

These arguments should not delay progress in the construction of artificial organs. They are brought up only to indicate the necessity of simultaneous work by competent, progressive, and properly educated people in an integrated way.

(C) *As to the study of human systems,* for a more objective understanding of their construction and function, the approach to these problems by medicine should indeed imitate the logical approach that other sciences are using. The problems may be immense and a systems analysis should be the first step. To give an example, the computer analysis of the function of the human arm by the Temple University group was later used for the functional control of a prosthetic arm.

Computer analysis of a televisioned image married to a computer-analyzed chart of the light-sensing cortex of the occipital lobe of the human brain may one day lead to an actually seeing artificial eye. ◄

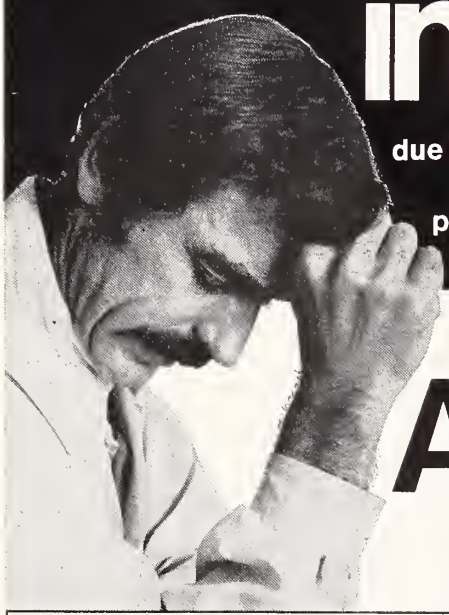
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T. Jakobovits
Fertility and Sterility, January 1970
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Warnings: Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

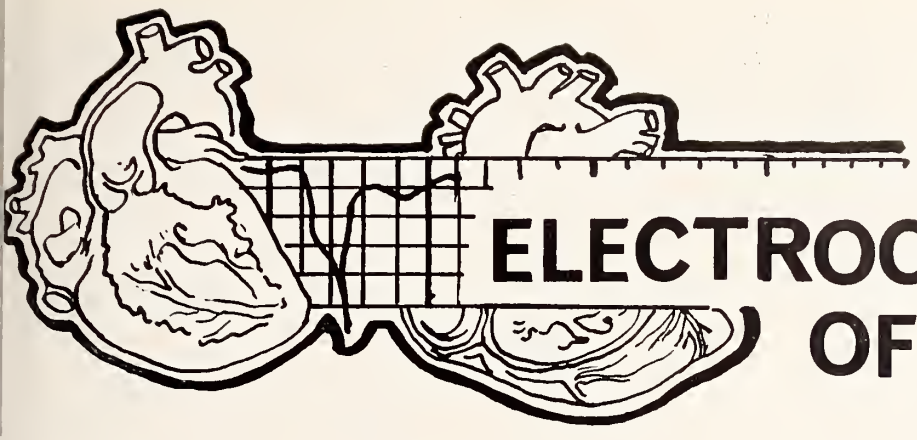
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References: 1. **Montesano, P., and Evangelista, I.** Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. **Dublin, M. F.** Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. **Heilman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. **Dsol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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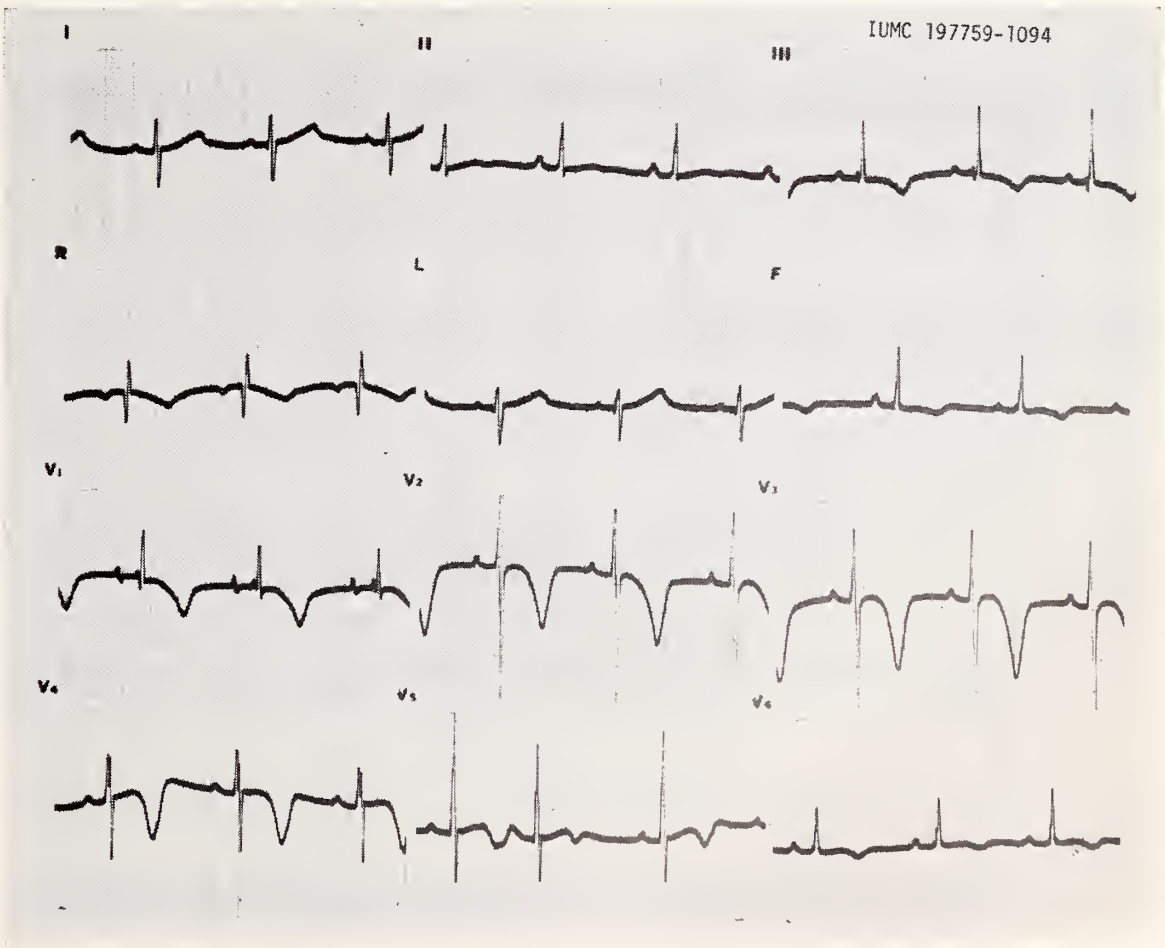
ELECTROCARDIOGRAM OF THE MONTH

The Nonspecificity of the Electrocardiographic QRS-STT Changes

CHARLES FISCH, M.D.

*Indianapolis**

ONE of the most difficult concepts to accept is that the ECG is a laboratory tool which registers only the electrical phenomenon. There is nothing in the ECG which, per se, gives information about either the functional (mechanical) or anatomical status of the heart. The extrapolation from the ECG to the above variables is a statistical one, arrived at by clinical and laboratory correlation of a large number of cases. Being a statistical correlation is a built-in significant irreducible error. This error can be minimized only if



* From the Krannert Institute of Cardiology, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis 46202.

the final ECG diagnosis is made by the clinician who correlates the ECG findings with all the other available clinical and laboratory data.

A correct correlation of the *numerous causes* of the QRS-STT ECG changes with the patient's problem can be made only by the clinician responsible for the patient. The electrocardiographer given a sufficient amount of information on the requisition or, preferably, by discussing the problem with the primary physician can make a reasonable clinical correlation. This problem is not obviated, but actually compounded by the presently available computer programs.

A classical problem is presented in the accompanying figure. This is an example of the *numerous ECGs* in which the only change is an abnormality of the STT component. A differential diagnosis from the ECG alone of the etiology of the ST-T changes is most often impossible.

An interpretation of the accompanying ECG would be one of non-specific T changes. Statistically deeply inverted, symmetrical T wave inversion is seen with acute coronary insufficiency or subendocardial infarction, cerebrovascular accidents or following cardiac resuscitation.

In this case, however, the patient was a 16-year-old girl with Mediterranean anemia during the acute crisis. The T waves returned to normal when the crisis subsided and anemia was corrected. This was a recurrent phenomenon! ◄

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The New Hope Foundation

THE extended care of a severely and permanently handicapped dependent is always of concern to those who are entrusted with his security. Provision of lifetime care after the death of parents or guardian is a matter of heartache and worry.

The future of a patient facing a lifetime of dependence on others need no longer be a question in Indiana. The New Hope Foundation is constructing a residential and outpatient building in Indianapolis which will provide residential wings, as well as full clinical, dental and therapeutic facilities. Areas for educational, vocational, and recreational activity are also included.

The New Hope Foundation plan carries a guarantee of lifelong care of a handicapped individual upon the retirement, disability or death of the parent or guardian. This is made possible by the member's participation in an insured equity program, through which an endowment fund is built. The yield of this fund provides for the handicapped beneficiary in a New Hope Care Facility when his parent or guardian can no longer supply it.

Similar facilities are planned throughout the country. Grants, donations, and private funds are used to purchase land and erect the facilities.

The New Hope approach to long term care includes all the comprehensive services needed for the lifetime management of an individual who cannot live independently.

Guaranteed care for life is assured under the terms of the Deferred Custodial Agreement which is paid for by monthly premiums paid by the parent or guardian during the principal's lifetime. Upon his death, permanent disability, or retirement the Agreement matures and the funds are expended in the interest of the handicapped dependent during the remainder of the dependent's life.

The plan is constructed and funded upon actuarial principles and builds up a reserve fund in the same manner as does an endowment life insurance policy.

A handicapped dependent who may require immediate placement in a New Hope facility during the active lifetime of his guardian may be cared for under an Immediate Placement Custodial Care Contract, the cost of which is negotiated at the time.

Individuals may become associated with the Foundation by establishing an Agreement for a dependent, by becoming a sponsor for a handicapped person whose family cannot afford such a plan, or by becoming a supporting member of the Foundation by an annual contribution of $10. Donors may also participate by providing single donations to be used for acquisition of land and buildings.

All contributions are deductible for income tax purposes. The Foundation is a tax-exempt, not-for-profit corporation. The parents, guardians, and professional people who form the Trustee membership of the Foundation elect the New Hope board of directors, which supervises the care of residents.

New and original programs to be developed at New Hope include self care, behavior shaping, pre-school activities and education, as well as physical, occupational, speech, music and recreational therapy, developmental workshop training, and group and individual counseling. It will provide for the severely handicapped individual not only custodial care but also the educational and rehabilitation services which will enable the individual to develop a satisfying life plan.

For complete information write: New Hope Foundation, Inc., 6100 N. Keystone Ave., Indianapolis 46220.

Pharmaceutical Progress Hindered

W. H. Conzen, president of Schering Corporation, and chairman of the Pharmaceutical Manufacturers Association, recently addressed the Pharmaceutical Wholesalers Association.

Mr. Conzen pointed out that change does not always indicate progress; and that changes in government regulation have hindered progress in the pharmaceutical field.

He attributes this to the fact that the FDA is prone to over-react to new developments and to reject new drugs or circumscribe their use so severely as to lose the advantages of new discoveries. This tendency not only threatens new products but also the pre-1962 new drugs which have recently been reviewed by the National Academy of Sciences-National Research Council.

Mr. Conzen illustrated his stand by stating that, in the viewpoint of the public, the impression is that an exhaustive clinical study has been performed. As a matter of fact, the NAS-NRC did no clinical research, but merely rendered opinions as to effectiveness; and although members of all the panels were distinguished men, the great majority of them had academic affiliations only and are not concerned with drugs as are the practicing physicians.

At least one of the NAS-NRC panel members has publicly stated that he is alarmed at the interpretation the FDA has placed on the Council reports. Mr. Conzen says that "It seems highly doubtful that they (the NAS-NRC panels) had in mind the actual removal of products from the market—an interpretation the FDA has adopted."

He also quoted a statement from the review which says that the "final arbiter of the value of a drug is the consensus of the experience of critical physicians in its use in the practice of medicine over a period of years."

Mr. Conzen considers the opinions regarding fixed combinations to be typical. A few NAS-NRC panel members object to some fixed combinations and possibly rightfully so. However the FDA has apparently adopted the attitude that all fixed combinations are bad and should be eliminated. He mentions that combination products not only decrease medication error but are less costly, are easier to administer and, at times, are necessary to broaden the spectrum of treatment when diagnosis is delayed or not easily made.

He concluded his speech by stressing the need for cooperation among government, academia and industry. He paid tribute to the pharmaceutical industry for its massive expenditures in research.

How Many is Enough Doctors?

THE following editorial comment in THE MEDICAL JOURNAL OF AUSTRALIA introduces a discussion of "Medical Manpower and Migration of Doctors". While the situation in the Philippines is cited by the Australian editor to illustrate one facet of the international migration of physicians, it may also be worthy of consideration when the United States discusses its problems of insufficient doctor coverage in the rural areas and slums. The Philippines have produced doctors to the point where less than half of them practice medicine and the outlying Filipinos have almost no doctors.

> "In a country that has too many physicians, where do all the doctors go? Some drive taxis.

"This deliberately eye-catching statement introduces a recent discussion[1] of the medical manpower situation in the Philippines. But if it seems startling, it pales beside further facts: that the estimated ratio of doctors to population in Manila is between 1:250 and 1:500, and in the outlying hamlets of the Philippines it is about 1:5,000; that 13% of total registered Filipino doctors are "permanently" practicing abroad; that 53% are not practicing medicine at all.

"We quote these facts, not in any way to be critical of the Philippines or of our medical colleagues there, but because they highlight what is a world-wide problem—the unsatisfactory and in many ways incongruous situations relating to medical manpower in a world that is increasingly expecting health care as a human right and all too often finds it hard to get. The easiest generalization to make is that there are too few doctors in the world, and this can be readily supported. But its truth as a generalization is so hung about with qualifications and questions that the glib comment "we need more doctors" will not do at all as an answer to the problems. Even in an affluent, relatively uncomplicated country with a fairly small population like Australia, it is immediately apparent that the graduation of more doctors is not the only, or even the necessary, answer to problems of under-doctored areas. A little thought will bring to light many other relevant factors. And on the international scene the medical manpower problem is highly complex and to some extent baffling — but far too important and urgent to be given up on that account."

Guest Editorials

Drugs

THE self-defeating nature of the consumerism championed by Ralph Nader and the F.D.A. is well-illustrated by the attitude patients seem to be developing toward drugs. Many are convinced that drugs are addicting, habituating, teratogenic, contaminated and lethally poisonous, as well as over-priced and generally

unnecessary. Little or no pharmacologic distinction is made between drugs, and it sometimes seems forgotten that drugs save lives.

A too-frequent question heard in doctors' offices is "Will I get hooked on this?" The question in some respects is commendable, demonstrating as it does a proper caution about things taken internally and a respect and concern for the welfare of his own body. It is laudable in that it also expresses an unwillingness to include himself among that pathetic group of instant joy seekers we generally refer to as potheads or junkies. But unfortunately the question probably indicates that this patient is not going to take the medication as prescribed, no matter what reply he gets.

We have no way of estimating the number of patients who end up inadequately treated as a result of misguided concerns such as this. We suspect the number is substantial. A sizeable number, no doubt, end up hospitalized because of "refractory" conditions. We suppose it must have occurred, but we have not heard of any diabetic withdrawing himself from insulin or a cardiac patient from digitalis because he found himself "hooked on dope." We are familiar with instances of psychiatric patients stopping their medication after watching a drug abuse commercial on television and then having to be rehospitalized.

We encourage drug abuse education but we discourage folly. Somewhere it should be said: MEDICINE IS GOOD; DRUGS ARE GOOD; PILLS ARE GOOD;PEOPLE WHO MISUSE GOOD DRUGS ARE BAD. **—*The West Virginia Medical Journal*, June 1971. Reprinted with permission.**

Divide and Conquer!

THIS past month for reasons unknown to us we have received several copies of an editorial written by Walter Walthall, M.D., President of the Texas Medical Association. It appeared in the December 1970 issue of *Texas Medicine* and was entitled "Let's Keep Our Team Intact." To summarize the editorial briefly, Dr. Walthall emphasizes the close relationship that has existed over the years between the pharmacist, pharmaceutical representative and the physician. He calls attention to the fact that this has been of great benefit to the patient. His message—"Let's Keep Our Team Intact."

At the same time this editorial was crossing our desk from several sources, the trade or professional press is full of news that would indicate the team is suffering the pangs of a painful separation.

The APhA is urging pharmacists and their associations to seek support from consumerist groups, the press and government officials urging support of the repeal of anti-substitution laws, the UAW President joins in, the Boston mayor is calling for posted price lists for 100 most used pharmaceuticals and the Connecticut legislature is talking about a bill to force physicians to write the name of the drug on a prescription in such a way that the patient can shop for the brand he wants. Other problems too numerous to mention are on the way.

We cannot help but note the can of worms designated "consumerism" has been opened and there will be no way to put the lid on it. What is happening in Boston is only the beginning. Pharmacy needs to come up with some realistic solutions to these problems—in the interest of the patient! Pharmacy needs to join hands with the physician and the pharmaceutical manufacturer to solve these problems—in the interest of the patient.

To turn a patient loose in the market with a prescription—"Some antibiotic three times a day" may seem ridiculous, but the consumer groups in their naivete think this is the answer to their problems.

A patient walks in the pharmacy and the pharmacist points to the shelf marked antibiotics and says, "Take your pick." The prices are on each package and the patient takes his pick. There are leaders in pharmacy, who would reduce the pharmacist's role to this. Somehow they have mesmerized themselves into thinking this consumer is going to be more satisfied with the pharmacist's selection of drugs than the physician's. Somehow they have arrived at the conclusion that once you introduce the price issue it will stop at the doorstep of the pharmacy. Our guess is—it may stop there with disastrous effects—NOT just for the pharmacist, BUT for the patient!

Our only hope, if we follow the line of thinking now being proposed, lies in the innate wisdom of the patient. We can hope that he will want quality. We can hope he will respect his own good health enough to demand the very best.

It's a strange situation we have, when the champions of mediocrity in pharmaceutical products and services are in our own ranks.

We should rise up in righteous indignation at everything that has been proposed by the mayors and legislatures—not only as an affront to pharmacy, but as an affront to the patient. Where are the voices for quality professional services and professional dignity? Some voices are strangely silent.

Are we to sacrifice the profession on the altar of anti-substitution? OR do we join forces to provide the finest pharmaceutical service to our patients?

The can is opened—it may be too late to put the lid on. We can join hands and keep the team intact.

—*Action in Pharmacy*, March 1971. Reprinted with permission.

We Can All Help Cut Government Costs

Nobody likes taxation. And everybody pays lip service to fiscal integrity. How does it happen, therefore, that our Federal Government is spending $195 billion this fiscal year, compared with $92 billion 10 years ago? The reasons are very human and we all must share the guilt.

Citizens have let the spending power be transferred to Washington. It is an axiom that the farther you remove the decision-making process the more tolerant the citizen will be of those who spend his money. And this is logical.

The New England town meeting could argue all night over whether to re-plank the covered bridge, because the meeting was in complete control of the project.

But when it comes to federal expenditures, how do you meet the argument that if Louisville doesn't take the money, Los Angeles or Las Vegas will? Immediately, we all come running with our begging bowls.

Then, there is also the comfortable delusion that if we can get the Federal Government to pay for it, we won't have to. So we seek Hill-Burton funds for the new hospital wing, overlooking the fact that while some of the money will certainly come from elsewhere, other hospitals also will be built elsewhere, partly out of our money.

Government has grown to the point where interest on the national debt is costing $17 billion this fiscal year. The total Federal Budget in fiscal 1941, as we entered World War II, was $14 billion.

We must all learn to stretch out our druthers. We can't have it all—not the whole bag, not right now. We've got to learn to wait another year for the new expressway, to put up with the old harbor breakwater for a few years more.

It's nice to have a Great White Father in Washington. But let's not let him become the kind of a Great White Father who showered his blessings upon the trusting Cherokees and naive Sioux.—**Jenkin Lloyd Jones, President, Chamber of Commerce of the United States.**

Editorial Notes . .

While children may be taught to swim at a very young age, it is not advisable to start training until they are at least three years old. The American Academy of Pediatrics points out that water safety and the proper reaction to an emergency cannot be taught before three and that the ability of the infant to swim a few strokes may develop a false sense of security in the parents. Also, some infants have age-specific immunity handicaps which will increase their susceptibility to viral diseases in the early years, types of viruses which may be present in pools but are not likely to be found in the home.

New York University Medical Center announces production of a serum which achieves immunization against serum hepatitis. It was found that the boiling for one minute of serum made from the MS-2 (serum hepatitis) strain of virus destroyed the infectivity of the substance without affecting its antigenicity. The researchers think that this will lead to the making of a vaccine which will be able to produce active immunization.

The Committee on Problems of Drug Dependence of the National Research Committee has issued a brief report which outlines the care that should be exercised in providing daily doses of methadone to rehabilitate heroin addicts. Copies may be obtained by addressing Brad Byers, Public Information Officer, 2101 Constitution Ave., Washington, D.C. 20418.

The fact that the price of prescription drugs has decreased steadily while the prices of most all other necessities have risen has not reduced the total drug bill for two reasons. The population has increased by 22.2% during the past decade. The number of prescriptions per capita has increased even more during the same time, from 4.1 per capita in 1960 to 6.5 in 1970—an increase of 58.5%.

During 1969 a total of 23,662 licenses were issued to practice medicine and surgery (an increase of 1,846 over the previous year) 7,762 by written examination and 15,990 by reciprocity or endorsement of state licenses by the certificate of the National Board of Medical Examiners.

Schools of nursing in the U.S. report a sizable increase in admissions—1969-70 had 17.4% more admissions than the year previous. The National League for Nursing points out that, while this increase is heartening, even more gains in the numbers of RNs would be desirable. The national shortage is approximately 150,000.

Post-transfusion hepatitis may be reduced considerably by the use of hepatitis associated antibody. The National Institutes of Health have issued a license to Becton, Dickinson and Company to produce and market the antibody. Approximately 25% of donor bloods containing hepatitis associated antigen can be identified by use of the antibody.

The University of Washington School of Medicine in Seattle will begin to expand medical education with the aid of a grant of $996,678 from the Commonwealth Fund. The states of Washington, Alaska, Montana, and Idaho will be included in a plan which resembles the Indiana Plan. Parts of the curriculum have been selected as suitable for off-the-campus teaching by colleges, other universities and community hospitals.

"Legal Notes" in the *Oklahoma State Medical Association News* advises that mention of the symptoms of side effects should be included on a prescription. Good evidence in case the doctor needs to prove that he has instructed the patient. Also advised is good penmanship, patient's full name and address, patient's age, and specific directions. A record should be kept of all prescriptions.

A memory-transfer agent has been synthesized at Baylor University. A substance originally found when extracted from the brain of a conditioned animal has been uncoded and made synthetically. A normal animal injected with the natural substance will adopt the conditioned behavior of the conditioned animal. Work so far with the synthetic compound demonstrates that its efficacy is transient.

The Veterans Administration, for the fourth consecutive year, will conduct training programs in three VA hospitals for clergymen who wish to learn more concerning the problems of the sick. The program at Houston runs for 12 months, those at Bedford, Mass., and Martinez, Calif., are for 9 months. The programs are inter-faith and are affiliated with graduate schools. Graduates of former programs have places of service in local parishes, institutional chaplaincies, health centers and as teachers of other clergymen.

A study of 500 infants shows that almost half fell from a high place, such as an adult bed, a crib or an infant dressing table, during their first year of life, according to the Health Insurance Institute. Most of them fell head first. The Institute urges that adults caring for infants should be instructed in the possibilities. Also the manufacturers of furniture designed for care of infants should be advised, since one out of three of the falling babies did so from just such furniture.

Colorado recently observed "Population Concern Week" with widespread publicity which utilized the abstract symbol of the two-child family. Zero population growth was popularized by numerous and well attended public meetings. The Colorado legislature is considering a bill which would limit Colorado income tax exemptions to two children born on or after January 1, 1972. Another practical bill being considered would give every mother entitled to Aid to Dependent Children an additional $50 bonus for every three-month period during which she did not bear children if she had two or more children on July 1, 1971; also if she had one child on that date and did not have more than one additional child; or if she did not have any children on July 1, 1971 and had no more than two children subsequently.

The National Society for Medical Research has announced that a new vaccine, which promises to be effective against influenzal meningitis, has passed safety tests and is expected to go on field trial soon. There are about 27,000 children affected with this type of meningitis each year. About 30% of them suffer long-term disability and 2,000 die.

There are a lot of things that are never seen in newspapers. When the FDA announced a list of 359 drug products, that were considered "ineffective" or to have "an unfavorable benefit to risk ratio," the impression was created that a new, large-scale action, based on incontrovertible scientific evidence, was being taken against hundreds of products still in use. Actually the list represented many regulatory actions taken over a two-year period. It contained both over-the-counter and prescription drugs. Some of the items represented varied dosage forms and package sizes for the same drug. The Pharmaceutical Manufacturers Association found that 292 of the items were manufactured by member companies, and that two-thirds of the products are already off the market. Three of the products were never marketed in the U.S. Another 25 ceased to be marketed before January 1968, some as long as 20 years ago. Aside from the above items, 172 of the products were removed from the market over the past three years. This leaves 92 still on the market, and in virtually all these instances the manufacturer is responding to FDA requests for more data on effectiveness.

While the Veterans Administration helps all veterans, it makes a special effort to assist those without a high school education. Veterans can get monthly payments while completing high school under the GI bill without having their payments charged against the education and training benefits for which they may be eligible. Since May 1968 there have been 2,180,269 Vietnam era veterans including 336,474 high school dropouts.

Grants for the development and application of a computerized system to help teach and test the complex clinical skills of the physician are announced by the Commonwealth Fund and Carnegie Corporation. Support totaling $611,800 from the two foundations will go to the project to be conducted by the National Board of Medical Examiners and the American Board of Internal Medicine. Both oral examinations and paper-and-pencil tests are now considered highly inadequate for determining how well a physician can care for his patients. The National Board has already demonstrated the advantages and potential of computer technology for examinations. The grants will allow further exploration into molding the technic as a tool for measurement of clinical efficiency.

The 1970 Student-Faculty-Physician Retreat*

JERRY A. ROYER, M.D.

EDWARD A. TYLER, M.D.

STEVEN C. BEERING, M.D.

Indianapolis

PATRICK J. V. CORCORAN, M.D.

Evansville

LAST September, a group of students, practicing physicians and faculty participated in a weekend retreat at French Lick jointly sponsored by the Indiana State Medical Association and the Indiana University School of Medicine. The goals for this retreat were dialogue and rapprochement; students, practitioners, and faculty met to interact and discuss current problems in health care education and delivery. The conference format emphasized small-group activity, with limited formal presentations. Specifically, the retreat featured three kinds of activity: a) an initial brainstorming session, b) an opening plenary session, c) workshop groups.

Initial Session: Brainstorming

The initial session was spent brainstorming, an extemporaneous exercise in which group members list their spontaneous, initial reactions to a given topic; in a limited time period (e.g., only five minutes per question), the premium is on volume and free-flow of thought, the group not pausing to evaluate the accuracy or relevance of any person's contribution. For this exercise, participants separated to their respective groups — students in one group, physicians in another, and faculty in a third. Each group tackled six questions designed to elicit their attitudes toward the other two groups. The *students*, for example, brainstormed these questions:

1a. What are current issues for *faculty?*

1b. What are current issues for *physicians?*

2a. What could *faculty* understand better or do differently in their work with *students?*

2b. What could *physicians* understand better or do differently in their work with *students?*

3a. What do you think *faculty* are saying that *students* could understand better or do differently in their work with *faculty?*

3b. What do you think *physicians* are saying that *students* could understand better or do differently in their work with *physicians?*

These questions were appropriately modified (*italicized* words changed for the other two groups): the physicians brainstorming about students and faculty, the faculty brainstorming about students and physicians.

The benefits of initial brainstorming were several: 1) Participants immediately found themselves actively, energetically involved in the retreat. 2) In an age of tardiness, the brainstorming exercise absorbed latecomers with minimal disruption, forestalling the opening plenary session until the retreat was at full complement. 3) The exercise provided insight into the attitudes of students, physicians and faculty. (For a complete listing of the brainstorming topics, group by group, send for copy of complete report.)

Summarily, *students* felt that physicians are primarily concerned about lawsuits (malpractice), money, Medicare, galloping socialism, radical medical students and crowded hospital facilities; students felt that physicians *should* confront current social medical problems (e.g., abortion, drug abuse, health care delivery) and should grant students greater patient responsibility. Students felt that *faculty* are primarily concerned about their own ego (image) and salaries, that faculty should prepare and present better lectures, should work for interdepartmental cooperation and should enlist more clinicians as basic science teachers.

Faculty described students as primarily concerned about relevance, but also concerned about health care delivery, finances and the draft; faculty felt that students should be more concerned about their individual learning needs. Faculty felt that *physicians* are primarily concerned about federal intervention and insufficient physician manpower, adding that physicians should be less resistant to change.

Physicians found students primarily concerned about ghetto medical

* For a copy of the complete conference report, write to Dr. Jerry Royer, 1100 West Michigan Street, Indianapolis 46202.

care, administrative problems, housing and money; physicians described *faculty* as primarily concerned about money, research, and status. Physicians felt that both students and faculty should better understand the reality of private practice: the pressure, the paperwork, the financial obligations, the difficulty of securing postgraduate education and increasing governmental intervention.

Plenary Session

Whereas brainstorming questions elicited each group's perceived concerns of the *other* two groups, the plenary session had each group presenting its *own* concerns. Discussing the satisfactions and frustrations of their respective groups were Dr. Patrick Corcoran and Dr. Betty Dukes for the physicians, Mr. Jacob Goldberger and Mr. Richard Schoen for the students, and Dr. Arthur Norins and Dr. Charles Hunter for the faculty.

Dr. Corcoran (Director, Evansville Center for Medical Education) outlined the satisfactions of being a practicing physician: the physician is independent, self-reliant (though paradoxically often a slave to patients and telephone); his profession rests on natural science laws which are unchangeable (cf. the changing principles of law, of theology); the physician yet enjoys the esteem of many people; he finds himself in a sellers' market—not concerned about forced retirement. Conversely, frustrations include: the unremitting work load (which erodes family life), the burdensome paperwork, the increasing legal hazards, the difficulty of obtaining consultation (availability of specialists), and the decreasing esteem and authority (especially in hospitals). Finally, Dr. Corcoran voiced concern about the future: possible civilian conscription of physicians, possible national licensure and relicensure exams, the delegation of responsibility to paramedical personnel, and the eventual stratification of the profession (i.e., primary physician, community consultant, major consultant at medical center, administrator, teacher, researcher). Continuing for the physicians, Dr. Betty Dukes (family practice, Dugger) related the rewards of medical practice, as she saw them: the personal satisfaction and the professional challenge, as well as the financial rewards. Concerned about the need for more primary physicians, she predicted that we will see increasing group practice.

As first student speaker, Mr. Goldberger (fourth year medical student) described the student's difficulty perceiving the scope of the problem, setting priorities, and then securing action once recommendations have been made; he outlined current problems facing the profession (drugs, abortion, health care for the poor), urging that retreat participants initiate an action program. Continuing for the students, Mr. Schoen (second year medical student) first voiced his own pessimism, stating that in his experience very little has resulted from retreats, moratoria, ecology days, etc. Then, after relating that medicine has indeed proved to be an exciting and dynamic field, he asked that the retreat have open debate on all issues (e.g., health care delivery, medical education), that there be more emphasis on the practice of community medicine, that we support changes in abortion laws, and that we respond to the drug culture. Most of all, he asked that we make him an optimist by making the retreat a starting point for action programs in the state of Indiana.

Faculty member Dr. Arthur Norins (professor of Dermatology, keynoted his remarks by sharing his greatest concern about practice: "Have I done everything I can and nothing wrong for my patient?" He then outlined a three-stage process on "How to Commit Education": 1) establish the goal, 2) outline the curriculum, 3) develop methods of instruction. Dr. Norins' goal: a physician who, beyond the formidable technical accomplishments, is an educated person: able to share responsibilities with other physicians while retaining independence, able to communicate with non-medical associates, and able to maintain respect for himself and his family. Regarding curriculum, he advocated greater coordination of basic and clinical sciences, and he emphasized the need to combat the bigness, the impersonalness, of a large medical center — by providing daily, small-group experiences. Concerning method, Dr. Norins said, "Spoon-feeding is the business of my profession, if by spoon-feeding you mean showing what is important, what should remain in a book and not clutter the brain, and showing interrelationships and simplifying difficult concepts." Rather than contributing to further information-input overload ("overkill"), the educator's role is *to motivate—to inspire, to stimulate.* The education must always attempt to evaluate the product—namely, have the goals been attained?

Continuing for the faculty, Dr. Charles Hunter (Professor and Chairman, Obstetrics-Gynecology) addressed the question: How can we better prepare physicians of the future? He then raised related questions: How can we better meet the need for evaluation—of course content and process, of individual student performance, of faculty as teachers? Having the nation's largest classes of medical students, how can we build class spirit and cohesiveness at Indiana University School of Medicine? These questions proved provocative, eluding simple answers.

Workshops

Each workshop (four physicians, four faculty, five students) met approximately 90 minutes Saturday

afternoon and another 90 minutes Sunday morning. This time was unstructured; workshops were free to pursue the brainstorming results, the plenary session topics, or venture in a different direction altogether. Hence, the range of topics considered by the four workshops was indeed wide. Nevertheless, all groups spent some time on issues related to health care delivery: e.g., improved care for minority groups, national health insurance, health care education, the Kaiser Permanente plan, physician manpower for small towns, the role of allied health personnel, compulsory national service (one year) for all medical school graduates. Two groups discussed issues related to medical education: quality of teaching, relevance of course work, emphasis on principles rather than facts and the implications of changing to a Pass-Fail system, replacing a system in which motivation was generated by fear. The workshops, unstructured as they were, experienced the frustration of not being able to solve the problems discussed, the frustration of not coming up with a specific program for action. This pressure for action goals was felt acutely by most participants.

Workshop leaders were asked to concentrate on the dynamics of group process, to facilitate group interaction. One workshop leader made the following process observations:

> The moderator intentionally did not give any structure. One physician requested everyone identify self and started himself. Physicians flaunted their credentials and status. (Faculty could have been expected to do this five years ago, but have learned this has no positive effect on students.) A student began to complain about the health care system, saying vaguely it doesn't work. A physician retorted: "Let me tell you about my personal health care service." Also implied was, "I am typical of the system." Students answered, "I know you are great, but the system does not work for everyone." Physicians countered, "Let me tell you it does, because I do this and this and this."
>
> End of the first session, frustration reigned; students and physicians were polarized, and faculty for the most part were not included or not participating. (Early in the session, one physician stated, "Our major problem is communication." At the time it sounded a mere cliche, but time proved he had identified the primary problem - a problem being acted out, though not identified, by the group.)
>
> The evening was a companionable one, an evening of informal exchange.
>
> Second session, there developed very quickly an openness and directness missing in the first session. The students were more open in attacking specifics in the system. The physicians defensively attacked systems other than fee-for-service health care delivery as being inefficient, ineffective and unequal. The students became increasingly realistic and less idealistic. Overall, they came to realize that the physicians were very dedicated, very hardworking men. This they were able to say, sincerely. In feeling less attacked, the physicians became more willing to grant flaws in the system. The frustration had shifted from sub-group communication to a mutual acceptance of the frustration of trying to improve the system. Overwhelmed by the massiveness of the system, students and physicians were allied in looking for some small unit with which they could come to grips. A model health care delivery system, researched and planned for the community, was the mutual recommendation.
>
> In my workshop group, faculty participants pointed out that they had not been engaged in much of the interaction except when they aggressively intruded; faculty wondered what they might do to help. "Nothing" was the answer from one physician. And other physicians and students implied agreement. I suspect both groups had such strong criticism of what the medical school (and its faculty) doesn't do that they were reluctant to open up at that late time.
>
> This was definitely a retreat in which practicing physicians and medical students increased their esteem and trust for each other. Maybe the message for the faculty is to be found in the fact that they were not "allowed to play," i.e., were kept in the role of outsiders.
>
> E.T.

This type of feedback, especially if available to the workshop while in process, is valuable in terms of group interaction.

Conclusion and Recommendations

Closing session, participants were asked to evaluate the retreat. The dominant value of the retreat, as voiced by all three groups, was that of rapprochement, of dialogue; participants reported "increased understanding" and "exchange of thinking and problems." Of interest: two participants described new introspective insights; and one faculty member noted changes in the attitudes of participants since the retreat a year previously, problems of group process (communication) having been bridged the past two years. That the retreat should be continued was unanimous, some participants stipulating, however, that the retreat be more action-oriented and with wider representation.

Accordingly, it is recommended that the student-faculty-physician retreat be continued on an annual basis, under co-sponsorship of the ISMA

and the IUSM. Furthermore, it is recommended that the retreat be a day longer and held in a more isolated, informal setting, and that the format be more structured, more action-oriented (though providing for abundant unstructured interaction, as well). To these ends—increasing esteem and trust among practitioners, students, and faculty as well as providing a forum for problem-solving on issues of health care delivery—the student-faculty-physician retreat can continue to contribute to medical education and care in the State of Indiana.

Participants

Students: Freshmen—Greg Darrow, Richard Jackson, Jane McDowell, Douglas Sheets, Craig Spence; Sophomores—Mel Brown, Tim Byers, George Kiracofe, Marjorie Lake, Eugene McDonald, Richard Schoen, David Smith; Juniors—Thomas Brooks, Robert Hunter, Stan Wissman; Seniors—Jacob Goldberger, John Wilson, Carolyn Yeager, Steve Young.

Faculty: Drs. Ray Antley, Steven Beering, Roy Behnke, James Carter, Joseph Fitzgerald, David Gibson, Charles Hunter, Wayne Johnson, C. Conrad Johnston, Joseph Mamlin, Raymond Murray, Arthur Norins, Jerry Royer, David Smith, John Svaan, Edward Tyler.

Physicians: Drs. Robert Arendell, Frank Bard, Dan Cannon, P.J.V. Corcoran, Harry Craig, Wayne Crockett, Betty Dukes, Joseph Dukes, J. Robert Edwards, John Farquhar, Thomas Gootee, George Haley, Bernard Rosenblatt, Merrill Rusher, Malcolm Scamahorn, Fred Smith.

Others: Dr. Clarke Mangun, Assistant Director, AMA Department of Continuing Medical Education; Mr. Robert Amick, ISMA Field Secretary. ◄

New Indiana Law Pertaining to The Immunization of School Children

HOUSE ENROLLED ACT No. 1128

AN ACT to amend IC 1971, 20-8-23 concerning the immunization of school children and screening tests for Sickle cell anemia.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 1971, 20-8-23-1 (formerly Acts 1957, c. 107, s. 1 as amended by Acts 1969, c. 149, s. 1) is amended as follows: Sec. 1. The school officials of each school corporation in the state of Indiana shall, upon the enrollment of any child in kindergarten or first grade, whichever constitutes enrollment for the first time, in any school of the school corporation, require the parents, guardian or any person having the control and custody of such child to furnish a written statement stating therein whether or not such child has been immunized against smallpox, diphtheria, whooping cough, tetanus, measles, German measles, poliomyelitis and whether or not such child has been tested for Sickle cell anemia, and the results thereof. The statement shall contain a recital showing the age of such child at the time he received such immunization. In no case shall a child be permitted to attend school more than thirty (30) days beyond the date of his enrollment without furnishing such a written statement.

SEC. 2. IC 1971, 20-8-23-2 (formerly Acts 1957, c. 107, s. 2 as amended by Acts 1969, c. 149, s.2) is amended as follows: Sec. 2. The school officials of each school corporation in the State of Indiana shall, not later than sixty (60) days after the enrollment of children for the first time in kindergarten or first grade in any school corporation, file a written report with the Indiana State Board of Health and the local health officer having jurisdiction in a manner as may be prescribed by the state board of health, stating in the report the number of children who have or have not been immunized against smallpox, diphtheria, whooping cough, tetanus, measles, German measles, poliomyelitis and the number who have or have not been tested for Sickle cell anemia. The report shall recite the names of the children who have been immunized or tested, the result of their tests, and the age when said children received such immunization or tests; and the report shall also recite the names of any children who have not been so immunized or tested. The Indiana state board of health shall prescribe and provide the forms on which the school officials shall make such report.

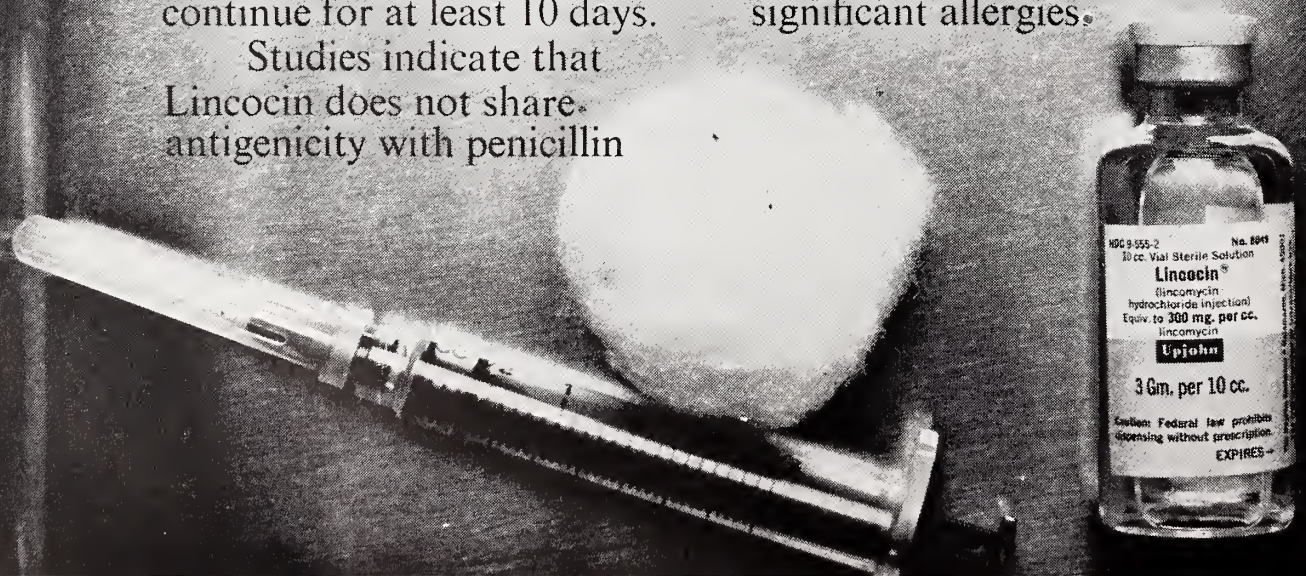
The school officials of any school corporation shall be required to file such report for any child who enrolls in kindergarten or first grade in any school of the school corporation for the first time after the report provided for in this section has been submitted to the state board of health.

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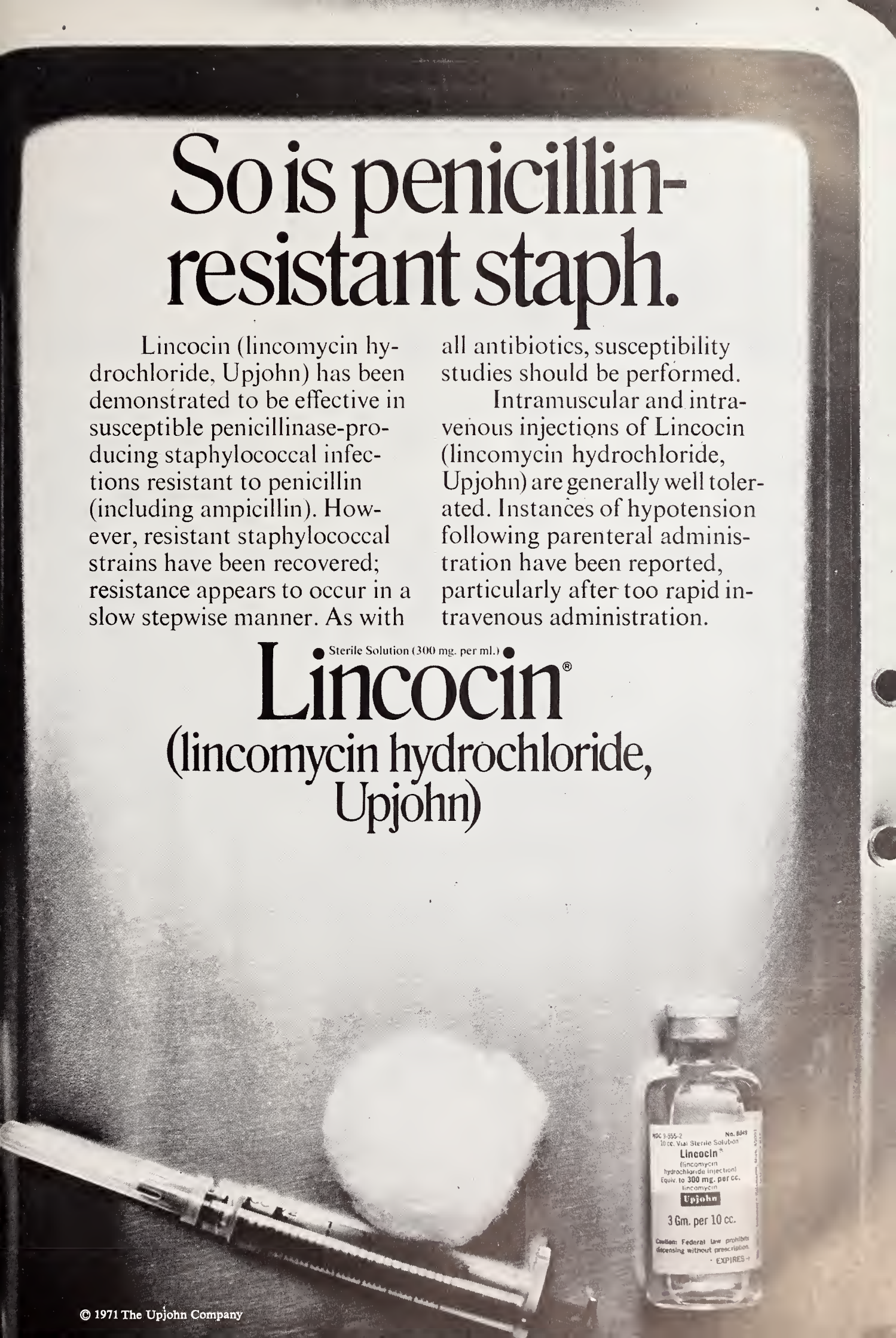
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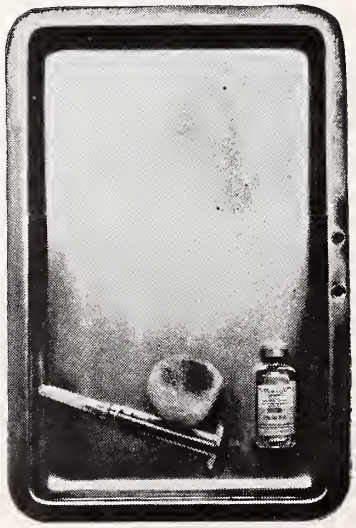
An antibiotic chemically distinct from others available, indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed.

CONTRAINDICATIONS: History of prior hypersensitivity to Lincocin (lincomycin hydrochloride). Not indicated in the treatment of viral or minor bacterial infections.

WARNINGS: Cases of severe and persistent diarrhea have been reported and at times drug discontinuance has been necessary. This diarrhea has been occasionally associated with blood and mucus and at times has resulted in acute colitis. This reaction usually has been associated with oral therapy, but occasionally has been reported following parenteral therapy. Although cross sensitivity to other antibiotics has not been demonstrated, make careful inquiry concerning previous allergies or sensitivities to drugs. Safety for use in pregnancy has not been established and Lincocin is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

PRECAUTIONS: Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of β-hemolytic streptococci infection for ten days to diminish likelihood of rheumatic fever or glomerulonephritis.

ADVERSE REACTIONS: *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatment. *Skin and mucous membranes*—Skin rashes, urticaria, vaginitis, and rare instances of exfoliative and vesiculobullous dermatitis have been reported. *Liver*—Although no direct relationship to liver dysfunction is established, jaundice and abnormal liver function tests (particularly serum transaminase) have been observed in a few instances.



Cardiovascular—Instances of hypotension following parenteral administration have been reported, particularly after too rapid I.V. administration. Rare instances of cardiopulmonary arrest have been reported after too rapid I.V. administration. If 4.0 grams or more administered I.V., dilute in 500 ml. of fluid and administer no faster than 100 ml. per hour. *Local reactions*—Excellent local tolerance demonstrated to intramuscularly administered Lincocin. Reports of pain following injection have been infrequent. Intravenous administration of Lincocin in 250 to 500 ml. of 5% glucose in distilled water or normal saline has produced no local irritation or phlebitis.

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Report of Commission On Governmental Medical Services

Interview with Director of State Welfare Department

MICHAEL J. MASTRANGALO, M.D.*

Fort Wayne

THE Commission on Governmental Medical Services met on April 21, 1971.

An interview with Mr. William Sterrett, the director of the State Welfare Department, provided much information. The following is an itemization of his accounting.

When Medicaid was first proposed and budgeted, there were 70,000 (1968) people on welfare in the state of Indiana and at the present time there are 156,000. The reasons for this increase were many and are listed.

1. Federal courts abolished the residence requirements.
2. The stepfather clause, in which he is not responsible for the children in a second marriage, provided welfare for non-supported children.
3. There would be continued assistance under Aid to Dependdent Children, even if an unrelated man was living in the house.
4. In order to stop welfare payments to a family on ADC, a hearing would be required. This usually fails.
5. The disregarding of subsequent income after being on welfare, for the first $30 of income does not count, plus ⅓ of the remainder of the income did not count and the cost of working, such as income tax, baby sitting, lunches, carfare, etc., did not count with regard to computing the basic income of the individual.

In this instance, Mr. Sterrett described a family in which the widow had gone back to work after a strike, at which time she was on welfare; although she had two children and was making $600 a month base pay, she was still allowed about $83 a month. He figured that she could remain on welfare until her gross pay was approximately $900.

General item number 2. Underlying the increase in welfare recipients are the activities of the Legal Aid Society and the Welfare Rights Organization. Mr. Sterrett has been sued 19 times in the past year in attempting to deny or remove people from the welfare rolls.

Because of the above, the cost of Medicaid in 1970 was $57,000,000, as compared to a projected $25,000,000. This represented approximately $28,000,000 paid to institutions and 8%, or $4,000,000, paid to physicians.

Total recipients and claims were included with the Commission's report but are not included in this publication of the report and are made part of the minutes. This also allows for examination of the January-February 1971 experience, in which the increase progresses and the average for the two months is $6,500,000 per month for Medicaid payments. Again, the institutions take a great part of this.

The statistics reveal that 70% of the physicians in the state of Indiana have used Medicaid for compensation on at least one occasion. Some attempt will be made by the Commission to obtain from Blue Shield the figure that would show some relationship to the number of claims per physician. It is felt that although 70% of the physicians have used it, the majority of the Medicaid is probably being carried on by a much smaller percentage of physicians in the state.

The predicted cost of Medicaid in 1971 is between $72,000,000 and $80,000,000. Of this, the state will be responsible for approximately $36,000,000 under the 48%-52% ratio.

Interestingly enough, Mr. Sterrett revealed that the cost of medical care *per welfare recipient* is only $1.00 more per month than in 1968, when the budget was determined. At that time, it was costing $38.00 per person per month, and at the present time it is costing $39.00 per person on welfare per month. This is still about $1,600 per year for a family of four.

His concern, however, was that Indiana is continuing to increase its number of welfare recipients and no plateau is in sight. There is 2.6% of the population of Indiana on welfare, as compared to a national average of 6.4 percent. Urban centers such as Gary have much higher percentage, in the range of 16 to 20 percent. It is feared that if a steel strike occurs this summer, the number of people on welfare will increase greatly.

The total state budget for the Welfare Department is in excess of $179,000,000 of state funds. Mr. Sterrett mentioned that in the state of Indiana approximately

* Chairman, ISMA Commission on Governmental Medical Services.

$500,000,000 a year from state and federal funds is budgeted for welfare programs.

There have been some cases of provider fraud; fortunately, none of the people involved are members of the State Medical Association. The Welfare Department will notify the medical society where there are any persons, be they members or otherwise, who are involved in a fraud situation, before they proceed with legal process.

Evidence of patient abuse has been discovered and the Welfare Department is planning to curtail this as well.

The cost of administering Medicaid by Blue Shield is now in the range of less than 5% of the total Medicaid bill. The per service cost of processing is approximately $1.20, as compared to the original start-up cost of $1.61. This, Mr. Sterrett feels, is a great improvement and Blue Shield has rebated moneys on occasion when costs of administration were reduced.

An organization in Indianapolis has apparently contracted with numerous physicians to accomplish collection of Medicaid claims for the physicians. This is not completely clear to the Commission; however, when a physician in this group, and it is apparently statewide, fills out the Medicaid form, he in turn states that the remittance be made to the organization in Indianapolis, called Indiana Credit and Accounting, Inc. This apparently is an organization that also advises the doctor on how to fill out the form to improve Medicaid collections. Whether there is any fraud or unethical arrangement in this matter will have to be looked into by the Board of Trustees or the appropriate commission of the Medical Society.

Although physician fees are fixed at the 1969 level of the usual and customary 75th percentile, the hospitals probably continue to receive full payment for their services. This is because of the cost-of-living escalator and also the fact that people on welfare receiving Medicaid usually have to sign over their property so that at their death it reverts to the Welfare Department. In attempting to settle these claims, Mr. Sterrett stated the cost would be excessive and it is best to leave the money where it is. This was not quite clear to all members of the Commission but, apparently, the one feature that the Commission was able to determine was that the individual physician provider is limited as to his compensation by the 75th percentile of old, usual and customary fees, while the hospital and other institutions apparently maintain a compensation that is in proportion to their present operating status. Mr. Sterrett was encouraged to try to improve the physician's lot.

The Welfare Department is attempting to raise the base for Medicaid payments to the physician to fees of July 1970, possibly at the same 75th percentile.

Some questions were asked of Mr. Sterrett regarding the above and he seemed to give satisfactory answers to all and it was a very informative and interesting interview. He did state that, in his opinion, the future of the practice of medicine would probably end up on a federal basis within a few years. He also stated that the capitation concept of practicing medicine, whereby the Welfare Department would contract to allow so many dollars per recipient per year for total care, a Medical Foundation or some other type of provider organization is in the picture. If any foundation or provider organization were in existence, Mr. Sterrett felt that it should provide full services, including physicians, pharmacists and institutional type of care.

With regard to a fiscal change from Blue Shield-Blue Cross, Mr. Sterrett said that he would consider this only on the basis that any future fiscal agent must provide the same services at the present cost and not be any more expensive to the taxpayer than Medicaid was at the present time with regard to administration.

After Mr. Sterrett left, a discussion of other means of providing medical care to the welfare community took place, including a small resume of the Medicredit plan of the A.M.A. It was felt to be a fairly satisfactory plan and could be recommended. Other plans before Congress at the present time are still in the committee stage. The commission felt that, at present, it would seem that the cost of medical care to the indigent was increased in the state of Indiana by the numbers of people covered and not by the person increase in cost. It was felt that some type of utilization control of the patient and possibly peer organizations might improve the economics of the Medicaid program.

The Commission then reviewed approximately nine CHAMPUS claims as satisfactory. One was not concluded because of a lack of complete information and it will be worked on at the next meeting.

The Commission then discussed the relative value schedule as determined by California, 1969, and it was felt that this was an adequate schedule; however, there were some areas, particularly in orthopedics, which might not be satisfactory. More study and discussion of this will be accomplished at the next meeting. ◄

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A revealing picture of child abuse patterns is provided by one study of the American Humane Society. More than half of the 662 children involved (all reported in newspapers within a single year) were less than 4 years of age. One fourth of the battered youngsters died; most of these deaths were of children less than 2 years of age. Fathers were more often guilty of child abuse than mothers, but sometimes both parents participated. The study indicated that battered children are not limited to any particular socioeconomic stratum.

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An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practitioners' Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*:267-279 (May) 1967. **2.** Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. *2*:193-199 (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. *2*:651-657 (June 14) 1969. **4.** Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem. *90*:365-380 (Nov.) 1969.

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Medical Morals in Society*

JACK W. HICKMAN, M.D.**

Tampa, Florida

PRACTITIONERS of medicine, individually and collectively, have been assaulted with a number of agonizing moral and ethical problems. This is not a problem of contemporary times only, although a number of factors have magnified and precipitated these stresses in recent years. It is not the purpose of this paper to serve as an apologia for physicians. The medical profession has had its full role to play in the instigation and perpetuation of some of the unpleasant situations in which it now finds itself. A full examination of the forces in general society demonstrates that medicine need not find itself with no reply other than mea culpa. The field of medicine does not stand alone in a vacuum untouched by the driving forces that are present in society at large, no matter how attractive this might be to the physicians themselves.

This paper will attempt to place the physician in proper prospective in his basic role in society. It will also investigate the important forces of materialism, depersonalization and scientific investigation, all of which have played their part in shaping medicine as we know it today.

The Physician

We can no longer view the physician as a pseudo-deity, a man above men, as was once the case. The day of incantations, secret remedies and magic potions has passed. This former draping of physicians in suprahuman cloth had its very useful purpose in an earlier era, and although there are those in the profession who would harken back, in large part because of their own insecurity, they can no longer expect to work in this mystical comfortable atmosphere. Improved communications, a sense that the public not only has the right, but demands "to know," all bring us out in the bright light of scrutiny. The practitioner, knowing that *Time* magazine featured idiopathic thrombocytopenic purpura in its medicine section this past week, cannot dismiss his patient with the statement that he has "some rare blood disease." All of us have been aware of a pulse-by-pulse account of the illnesses of each of our recent presidents. Etiology, pathophysiology, therapy, side-effect, contraindications—all are covered in magazines, radio and television broadcasts.

The nature of the illnesses and therapies are not all that are covered in these "tell all" communications. Not only do we know about the patient, but we will also be fully informed about the physician, and even the "medical team" that is caring for the patient. We will be told, whether we want to know or not, that the prominent heart surgeon arises every day at 6:00 a.m., has yogurt for breakfast, always reads the *Morning Chronicle* before leaving the house at 7:05 to drive to the hospital in his 1968 220SEB Mercedes Benz for a day of surgery. We also learn about his work habits, leisure habits, reading preferences, wife, children, house, tastes in music, ad infinitum.

Just as disease states have become common property, so has the physician.

This is the same practitioner of whom Hippocrates said, "A physician should be an upright man, instructed in the art of healing. . .modest, sober, patient, prompt to do his whole duty without anxiety, pious without going so far as superstition, conducting himself with propriety in his profession and in all the actions of his life." If the general public were able to view him in this same light, it would be somewhat surprising, when the wart on his nose has been described publicly.

If these changes in society have "humanized" the physician, we must, in honesty, not judge him by suprahuman values. If, as we really knew all along, the physician is human, we can expect him to posess the same instincts as anyone else, and not even with much in the way of quantitative differences either.

If the public now sees its emperor without his new clothes, we at least know with whom we are dealing and can set realistic standards for his performance based on those of society at large.

Materialism

One of the most frequently heard criticisms of medicine is its materialism. The golf-playing, Cadillac-driving image of the physician

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* Presented at a meeting of the Indianapolis Literary Club.

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has been so clearly drawn in many minds that it is hardly a compliment to your intelligence to dredge it up again. Yet we should examine it. To avoid it would be to dodge an accusation that has some basis in fact. Such pictures do not originate de novo. You will not find a denial of its existence in this presentation. A scientific line of investigation would have to involve a study of the frequency of this type of character behavior in physicians, as compared with a comparable group of men from a similar socio-economic status. No such study has been done, nor is even contemplated by this author. This syndrome is real enough that a recent issue of *The Scalpel,* the journal of the international premedical honor society, Alpha Epsilon Delta, contains a reference to it. In it there is an article by Dr. Carl Lechner which was presented to premedical students at their national convention. Dr. Lechner said, in part, "You will not make a better move than to enter this fellowship of the health professions - a brotherhood of many kinds of educated people who assist their fellow man in many ways. It takes all kinds of people to serve the variety of needs which are seen in such a great variety of people. Come into our guild with the resolution to meet the challenges of the study of mankind by achieving excellence in your practice. You may be sure that you will be supported by our society in your pursuit of excellence. But beware, when a measure of material success does come, that you do not go down the C-C path — of Country Clubs, Cabin Cruisers, Cadillacs, Continentals or, worse yet, Canadian Club." It is easier to accept the Cadillac-golf syndrome as extant, qualified by a certain distrust of its true frequency, than to examine its meaning.

Surely this syndrome represents no more than a specific manifestation of a more generalized aspect of our materialistic society. Conspicuous consumption, as first described by Veblen, has been known for many years and has been polished to a fine art in recent decades. *The Theory of the Leisure Class,* first published in 1899, has passages that cannot be surpassed today in accuracy of description and intuitiveness such as "Conspicuous consumption of valuable goods is a means of reputability to the gentleman of leisure. As wealth accumulates on his hands, his own unaided effort will not avail to sufficently put his opulence in evidence by this method. The aid of friends and competitors is therefore brought in by resorting to the giving of valuable presents and expensive feasts and entertainments." Why should we expect the physician to remain aloof from materialism when he is assaulted by it on all sides. Even our own government tells us that the United States has the highest standard of living the world has ever known.

A major thrust of government has been to bring all segments of our population to incomes above the poverty level, even though the poverty level may vary from year to year. I do not mean to disparage these programs. I mean merely to point out that the goals set are always financial ones—not spiritual or moral. This is not surprising, of course. It is far easier, even as difficult as it is, to improve per capita income than it is to enrich spiritual content.

A major point of consideration is: why did the physician come to be placed in the position of such relative affluence by society? The materialistic benefits that he reaps have been allowed by society for years. The current materialism has only enhanced them and increased the tinsel. Along with the benefits themselves has come prestige.

Surely society has been perfectly willing to provide the physician with preferential treatment and rewards because it so dearly wishes the product he offers - good health, relief of pain and extension of life. If the drive for pleasure and the avoidance of pain is as great as virtually all philosophers and pyschiatrists have told us, we should not find it surprising that the status of physicians is what it is. The basic underlying importance of the pleasure-pain impulses was demonstrated clearly by Socrates in his exchange with Protagoras:

I said, You would admit, Protagoras, that some men live well and others ill?

He assented.

And do you think that a man lives well who lives in pain and grief?

He does not.

But if he lives pleasantly to the end of his life, will he not in that case have lived well?

He will.

Then to live pleasantly is a good, and to live unpleasantly an evil?

Yes, he said, if the pleasure be good and honourable.

And do you, Protagoras, like the rest of the world, call some pleasant things evil and some painful things good? — for I am rather disposed to say that things are good in as far as they are pleasant, if they have no consequences of another sort, and in as far as they are painful they are bad.

Couple this desire for satisfaction with the urge for self-preservation and the physician's value becomes doubly clear.

We could argue that the clergy offers society something even greater.

They will instruct us in a set of moral precepts that will lead to everlasting life. One might think that society would reward the clergy even more lavishly than the physician. Is not everlasting life (and, after all, everlasting is a long time) a greater prize than having your Colles fracture mended? The fallacies in this argument are appar-

ent and unfortunately hinge on the failings of human nature. Man will not opt for everlasting life for a number of reasons. First of all, the Colles fracture is now. Everlasting life, we hope, is a long way off. Furthermore, we can tell very easily if the fracture mends, whereas we have no visible proof that what the clergy is telling us about everlasting life is really so. With man so tied to the temporal and tangible, it would be very surprising if he did not value most highly rewards that are of this nature.

We should not mistake the rewards offered the physician as being of too little importance, but they should be placed in correct perspective. We must also realize that this value scale is determined not by the physician, but by all of society, with its baser emotions duly represented.

Depersonalization

Another charge leveled at the medical profession in recent years deals with its cold, scientific approach to the patient. Even citizens who never saw a horse and buggy yearn wistfully for the return of that kind, compassionate type of practitioner. The usual response to this accusation by organized and individual physicians is an indirect and thinly veiled attack upon the competency of their earlier day colleagues. While it is factually true that yesterday's physician was not equipped as well scientifically, this defense is only partially true and probably does little to allay the more fundamental truth in the original charge. Of course, today's physician is less personal than was once the case. Society itself is less personal. In former years the computer had not found a way to entrench itself between individuals. A frequently heard statement that was unknown in former times is "I don't need your name, sir, just your bank identification number."

Society has told the physician very clearly what it wants by the nature of its grant support to medicine. For a number of years it has been relatively easy to obtain grant monies for research projects that will improve the scientific areas of medical investigation. If there has been any major support for improving the humanistic values relative to the practice of medicine, I am unaware of them. Deans and others have not brought in monies to improve the teaching aspects of their medical schools as a primary aim, but teaching has improved only, if at all, as a by-product of monies for basic research. Actually, in the last year or so it looks as if there may be a swing toward the educational aspects of the medical schools. Grant proposals intended primarily to improve teaching are at long last being considered favorably.

Governmental research grants, in general, have been in the scientific arena. We find no National Institutes of Culture that are comparable with the National Institute of Health, to say nothing of the National Aeronautical and Space Administration. This phenomenon is, of course, similar to ground we have already covered—man finds it far easier to support activities in areas that can be measured in finite terms. As difficult as it is for most of us to comprehend light years, that is still easier to grasp than the concepts of human behavior.

The official recommendations of the American Medical Association speak to both the materialistic and humanistic aspects of the practice of medicine. The AMA's judicial council says, in part:

"1. Character of the Physician; The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Whoever chooses this profession assumes the obligation to conduct himself in accord with its ideals. . . ."

And in section two of the same report: "One of the strongest holds of the profession on public approbation and support has been the age-old professional ideal of medical service to all, whether able to pay or not. That ideal is basic in our ethics. . . ."

I want to tell you about a physician in our neighboring state of Illinois who has attempted to follow these tenets quite closely. This man was apparently paying too much attention to them, and glossing over other demands of society, for he finds himself in about as much trouble as any of us would want. The case in point is Dr. Charles Gavin. Dr. Gavin has become the center of quite a controversy because he has been found guilty of income tax evasion. He has been sentenced to six months in prison and fined $7,500. Dr. Gavin has admitted that he did not file income tax returns for roughly five years after starting his practice in the Chicago Heights area in 1960. These facts seem straightforward enough, and by themselves not very unusual. Yet there are some interesting repercussions of the case that we should examine. To begin with, roughly 5,000 people have appealed to President Nixon for executive clemency for Dr. Gavin. Twenty-five staff members at St. James Hospital have offered to serve one week each of Dr. Gavin's sentence, and a woman from New Jersey has reportedly offered to serve the entire sentence herself. Why in the world have these unusual offers of support come forth?

I first heard of Dr. Gavin from one of our medical students who came to see me about the possibility of circulating a petition of support for him. This student, an extremely sensitive young man of high ideals, had once been a patient of Dr. Gavin. Dr. Gavin had operated on him, taken beautiful care of him, and refused to charge him for his services. This

seems to be the way that Dr. Gavin often ran his practice. He worked either in his office or the hospital 12 to 18 hours per day, seven days a week, and kept virtually no financial records of any kind. It has been learned that frequently he didn't bother to send out any bills. His claims for Medicare patients would have amounted to $100,000 over the five-year period — if he had only bothered to file for them, which he didn't.

This interesting question could be asked: If Dr. Gavin owes the government $7,500, does not the government owe Dr. Gavin $100,000 in uncollected Medicare payments? In fact, his colleagues have learned that he billed less than 40% of the persons he treated. It is not hard to imagine the miserable financial records that Dr. Gavin had to offer when investigated by the Internal Revenue Service.

Dr. Gavin seems to have taken too literally the statement that "the prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. . ." and "the age-old professional ideal of medical service to all, whether able to pay or not."

An editorial from station WBBM-TV in Chicago, from which many of the above facts have been drawn, concludes with "Society would be better served with Dr. Gavin in the operating room — rather than the jail."

The case of Dr. Gavin shows us, if nothing else, that at least one segment of society, the Internal Revenue Service, does not place physicians in any suprahuman category.

Of what else it shows us I am less sure. It points up a possible basic conflict between the demands of the profession and society in general. It tells us that humanitarianism itself is not enough, and it suggests that society says that the game is to be played with considerable attention to materialistic rules, which I guess we knew all along. Any other value judgments will have to be your own.

The AMA tenets clearly call the physician to levels of performance that are required of few other, if any, groups in our society. The general failings of society can be inferred from them, but at least the medical profession has been willing to warn against them in setting forth these goals. We can expect these tenets to be followed with about the same degree of success that we can expect from any other group. Actually, it would be more correct to say that members of groups fail, since obviously it comes down to individual performance.

Modern Science

A recent moral and ethical problem that has confronted medicine is that of prolonging life beyond what many consider usual circumstances. This problem has been brought to focus in the case of kidney transplants, artificial kidneys and, more recently, heart transplants. All of these procedures have come to fruition by large expenditures of money in the medical research arena. Through these procedures and others it is possible to prolong life beyond what would have been the case only a decade or so ago. As is usually the case, it seems that the wonderful world of science has created more problems than it has solved. Also, these problems fall outside the realm of science. Others are left to do the dirty work.

I should like to tell you, at this point, about Tommy. Tommy was one who received the most modern medical treatment a few years ago— and very successfully, as far as the treatment itself was concerned, but his story points out the non-scientific monster that science can create. Tommy was a 17 year old boy who was suffering from far advanced kidney failure. Episodes of glomerulonephritis had gradually eaten away at his kidneys to the point that he had virtually no remaining kidney function. Death would be no more than a few weeks away if standard medical management were followed. Tommy's family was devoted to him. Relatives were always visiting him. Friends from his home town also came frequently to see him. His walls were filled with "get well" cards. It was indeed sad to contemplate his death at such a young age.

The hospital staff had recently obtained and become proficient in the use of peritoneal dialysis equipment. With this equipment they could, by probably three treatments per week, remove the toxic products from his body that his kidneys could no longer remove. Such treatments would, under normal circumstances, be prohibitively expensive to all but the very rich, but it was agreed that it could be offered to Tommy, and written off as a research expense, rather than charging Tommy's family.

This possibility was presented to Tommy's parents, telling them very clearly that the treatment results would not be known, but that in any case they would be no more than palliative. Nothing could be done to keep Tommy alive forever. The treatments might prolong his life and, for a time, restore his strength. The family was overjoyed and accepted immediately. Treatments were begun, with the family always in evidence. The results were all that could have been hoped for. Tommy's mental picture cleared, and he gradually but definitely began to improve. His strength and appetite increased as did his general sense of well-being.

After about two months, the family members had learned how to perform the procedure of peritoneal dialysis themselves, and we were asked by them if it would be possible for Tommy to come home on weekends. Tommy would be taken home with

the equipment necessary for one dialysis treatment to be given by the family while he was home. This was agreed to and this arrangement seemed to work perfectly for a few months.

Then the staff was told occasionally that it would not be convenient for Tommy to come home for a certain weekend, for one reason or another. Either one member of the family would not be available to help with the dialysis treatment or there was a conflict of engagements that would make it impossible for the family to get Tommy this week. Gradually Tommy was going home every other weekend, and then, as the months grew to over a year, Tommy was going home perhaps one weekend each month. At this same time the visitors to Tommy's room at the hospital were becoming far fewer. There was no longer a problem for the nursing staff about restricting the visitors to his room, for fear that too many would unduly tire him. Few came. The "get well" cards were falling from the walls as the scotch tape yellowed and peeled loose — they were not rapidly replaced by new ones.

The treatments gradually began to lose their effectiveness. It had been over a year and a half since they had been instituted - a medically remarkable feat in itself. Tommy began to become quite ill again and to lose ground. When he died it was necessary to phone his family and inform them of the news — none were present with Tommy at the time of his death.

I have not told this story to, in any way, condemn Tommy's family. I fear that their reaction was one that many of us could expect. In fact, somewhat similar stress reactions have been described in the *British Medical Journal* within the past year, although the specific circumstances have varied from that of Tommy. I believe our friends in psychiatry would tell us that Tommy's family had really regarded him as dead months before his heart actually stopped. In this and similar cases it is difficult to determine who, if anyone, really benefited by such heroic measures. I find it difficult to defend the position that either Tommy or his family gained any benefit from the course that was followed.

The public has told medicine that it wants "progress" in medicine, and Tommy and his family received it.

Transplantation techniques have also raised new questions. Even the basic question of defining "death" has become a problem. It is important to know when a person may be considered dead, so that various organs can be removed to be transplanted to awaiting recipients. Lawyers, state legislators, the clergy, and physicians have been agonizing recently in attempts to define death. Just "the absence of life" will no longer suffice. This problem is even more complex, of course, because of the extremely effective, beautifully engineered life-support systems that now exist. These machines can maintain some semblance of cardio-respiratory activity for long durations of time in individuals so devastated by catastrophic illnesses that their bodies would have no chance of maintaining these vital functions unassisted. Simply stated, the practical problem is "when can we turn off the machines?"

Along with pinpointing the moment of death, we are beset by the problem of determining who has the legal right to donate the organs in question for transplantation. In most states, the next of kin has had the legal right to decide what shall be done with the remains of the deceased. This has superseded any expressed wishes of the deceased that he might have made known during his life. This situation has complicated life for the transplant teams and has often thwarted their efforts to obtain organs.

In the August 22, 1968, issue of *The New England Journal of Medicine*, there appears an article entitled "Organ Transplantation: A Proposal for Routine Salvaging of Cadaver Organs," by Mrs. Jesse Dukeminier, an attorney, and Dr. David Sanders, a physician who also has a degree in public health. Their proposal is really quite simple — it merely requires us to use a new starting point in our reasoning. It is not mentioned directly in the article, but it asks to have as our basic assumption that the individual exists for society. If we can accept this, then we should have no trouble with the authors' proposals. Their principles are: "Removal of useful cadaver organs is routine practice; leaving them to putrefy is unusual. Removal of organs is performed under conditions that do not burden the bereaved persons with the problem. The donor may object during life to removal of his organs after death, and the objection is controlling. If, however, the donor expressly agrees to the use of his organs after death, his next of kin has no power of veto. If the donor neither objects nor expressly assents, his next of kin may object to removal any time before the organs are removed, and the objection is controlling. This principle should be included to obviate any constitutional problem regarding freedom of religion."

Well, as you can see, these proposals would solve a number of practical problems about obtaining organs for transplantation. It is a simple solution, but it requires starting out from a different point. We might then find people carrying around cards saying that in case of death, their organs were *not* to be donated to medical science. It will indeed be interesting to see if the Dukeminier-Sanders proposal gains in popularity and becomes the basis for future legislative proposals.

Before concluding any discussion of transplants, I must include my favorite quotation of the year on this subject. Earlier I stated that the medical profession agonized over many of these moral problems. At least one physician in the thick of the transplantation arena does not have to agonize over the problem. In what must rank as the epitome of pragmatism, Dr. Denton Cooley is reported as saying: "Moral, religious and ethical objections to the heart transplants. . .without any basis. . .are hampering research and progress. This is no time for a witch hunt." Beautiful.

It is always easier to outline problems than to suggest equitable solutions, and this presentation has been no exception. It does seem fair to look at the physician as another stumbling human in our society. It is also fair to dissect out his moral problems in this age and view them as being indigenous to society as a whole. We should do this even though the problems may have the superficial appearance of being unique to medicine. Materialism, impersonalization and scientific progress exist all around us. It is of these elements that the problems of medical morals are created. Those of us who agonize over these problems should perhaps envy our Dr. Cooleys who go incisively to the heart of a problem and find that no problem exists. ◄

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—May 1971

Disease	May 1971	Apr. 1971	Mar. 1971	May 1970	May 1969
Animal Bites	1210	1291	580	1477	1431
Chickenpox	357	605	668	471	637
Conjunctivitis	218	215	167	129	199
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	20	33	18	14	36
Gonorrhea	527	559	470	715	582
Impetigo	79	81	125	90	98
Infectious Hepatitis	68	59	54	80	67
Infectious Mononucleosis	115	99	125	121	118
Influenza	810	2033	2896	734	1284
Measles					
Rubeola	720	704	429	53	133
Rubella	437	315	228	351	602
Meningococcic Meningitis	7	4	1	5	5
Meningitis, Other	6	8	1	3	2
Mumps	837	1123	1146	337	485
Pertussis (Whooping Cough)	9	14	14	17	9
Pneumonia	295	445	592	482	271
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	724	1016	1258	844	865
Syphilis					
Primary & Secondary	28	31	22	35	39
All Other Syphilis	83	126	90	168	118
Tinea Capitis	0	2	6	1	10
Tuberculosis (Active)	99	68	43	76	42

TAX TIPS



by LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

THE 1971 Indiana General Assembly made several changes in the intangibles tax, e.g., the law was amended in order to provide specific review and hearing procedures. But the most extraordinary change was to limit the potential past liabilities of taxpayers back to January 1, 1969.

As to the changes in the adjusted gross income tax, the three most significant ones were: to update the Indiana law in order to conform with the current federal income tax law; to grant more powers to aid the Indiana Department of Revenue to collect delinquent taxes; and, to allow the Indiana Commissioner to employ special counsel to collect delinquent taxes in any county. As to the gross income tax, the most important change was to impose the tax upon national banks as of July 1, 1971.

A recent insurance publication suggested that its readers might recommend the following plan to their clients in order to save federal estate taxes. The publication suggested that an individual could purchase a life insurance policy on his own life and have the policy payable to a charity. Then, the individual could make an irrevocable gift of the policy to the charity, but reserve the right to join in the exercise of any policy rights (jointly with the charity). By doing so, the insured's gross estate would be increased by the proceeds of the life insurance when the insured died (because he would have retained the right to exercise rights over the policy). However, the publication suggested that the increase in the insured's gross estate might *save* him estate taxes, because the insured would be entitled to an increased marital deduction in addition to a charitable contribution deduction. That is, the net effect would be that the increase in the insured's gross estate would be offset by the charitable contribution deduction (dollar for dollar), but the insured would be entitled to an *increased* marital deduction, which could save him estate taxes. The plan was in no way said to be fool-proof, and the publication explicitly stated that the I.R.S. might deny this double benefit. Further, I would add that any person who purchases insurance for the sole purpose of obtaining this potential estate tax savings should obtain a legal opinion, from his lawyer, as to the possible ramifications of such a plan. The expenses of litigating the results of business and estate plans which are in the *grey area*, can far exceed the tax-savings of the plans (and the cost of an advance legal opinion).

An I.R.S. ruling (Rev. Rul. 71-232) has just been issued which provides that where a donor makes a gift and requires that any federal gift tax must be paid by the donee, then the amount of the gift tax reduces the value of the gift for federal gift tax purposes. The ruling also provides a formula for determining the amount of the gift tax that may be deducted in determining the value of the gift that is subject to the gift tax.

Many lawyers are still wary about advising their Subchapter S corporations to issue debt to their shareholders for fear that the debt may be held to be a second class of stock (and thus terminate the Subchapter S election). While, as indicated above, caution generally saves more money in the tax game than aggression, it appears that the I.R.S. is going to lose its fight to categorize debt as a second class of stock regardless whether the debt is held pro rata or in staggered amounts by the shareholders.

If you are concerned with pollution control, then you might ask your lawyer for a copy of the new U.S. Treas. Regs. § 1.169-1 (a) (1), concerning the rapid depreciation of qualified pollution control facilities. Basically, the new Regulations allow a qualified pollution control facility, with a useful life of up to 15 years, to be depreciated for income tax purposes over 60 months.

Also, those of you who are serving as directors or officers of social clubs should ask your lawyer to send you a copy of the new proposed U.S. Regs. § 1,512 (a)-3(c) (2), § 1.512 (a)-3(c) (3)(iii), and Rev. Proc. 71-17 (TIR-1083, so as to prevent a possible tax on the income of the social club and to prevent loss of the club's income tax-exemption.

The I.R.S. has just announced that it will follow the decision in *A. W. Mitchell Estate,* 55 T.C. 576 (1970), namely, that an inter vivos trust will not be includable in a settlor's gross estate for federal estate tax purposes merely because the trustee has the discretionary power to distribute trust principal and income for the support and maintenance of the settlor's wife after taking into account the wife's income from other sources. This decision has answered one estate planning problem for lawyers and allows them more flexibility in planning estates. ◄

From the President's Desk

In late June our Indiana State Medical Association delegation attended the American Medical Association meeting in Atlantic City.



The highlight was a visit to the convention by President Richard M. Nixon. In his talk, Mr. Nixon called on the American physicians to support his Drug Abuse Program, be involved locally in the drug problem and generally to assume leadership in the community in civics as well as medicine.

The AMA House of Delegates discussed such things as HMOs, PSROs, PROs, health manpower, health insurance and medical education. Our delegates were active in shaping many of the final reports accepted by the House. Please read this Journal, the ISMA News Flash and the JAMA for details. Politically, Dr. Don Wood was elected to the Board of Trustees and Dr. Guy Owsley was re-elected to his Council post.

July is a vacation month, so Mrs. Scamahorn and I will relax by spending a few days with our family. As we take time off, let's all enjoy our vacations but remember to live and play carefully so we may return to our No. 1 vocation—the care of the sick of the State of Indiana. Have fun.

See you in August,

M. O. Scamahorn, MD

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ABSTRACTS, BOOK REVIEWS

ALZHEIMER'S DISEASE

Ciba Foundation Symposium edited by G. E. W. Wolstenholme and Maeve O'Connor; J. & A. Churchill, 104 Gloucester Place, London, 1970; 315 pages with numerous tables and microphotographs.

Alzheimer first described "presenile dementia" in 1907. The essence of the pathology is "granulovacuolar degeneration of the pyramidal cells of the hippocampus." Under the light microscope the gross changes in the neurofibrils, "the tangles," are clearly visible. Eponymically lumped with this condition we have diseases bearing such names as Pick, Lissauer, Creutzfeldt-Jakob, Kluver-Bucy, Leber, kuru, etc.

The electron microscope increased magnification by two magnitudes; we now have the possibility of seeing items magnified 100,000 times. We have acquired the ability of learning that —basically—the amyloid clogging the degenerating tissues comes from deposition of insoluble fragments of antibodies; the body does not have the enzymes capable of dissolving them! Apparently, "something" stimulates antibody formation. Plasma cells may manufacture an excess of light chains that never become incorporated in the total molecule. Lysosomes become clogged with these fragments. Result? All these variants on the same theme bearing these stultifying eponyms.

Now that we are learning the "what," we must proceed to the why and (maybe) the cure. In any case, the monograph is enlightening, indeed. It may be a harbinger of greater things to come. As usual, the binding, printing and paper are superb. Congratulations all around!

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

PROSTAGLANDINS

Annals of the N.Y. Academy of Sciences — Conference held Sept. 17-19, 1970, at the Academy of Science, edited by P. Ramwell and Jane Shaw, chaired by U. S. von Euler, Vol. 180, 580 pages, innumerable tables and illustrations.

The very name, PROSTAGLANDINS, was given some 40 years ago to some newly found traces of strange fatty acids hidden in truly minuscule amounts within the seminal fluids of sheep. Their colossal potency in nanogram quantities obtainable intrigued investigators of reproductive functions. We all can recall other such new classes of compounds: calcitonin, glucagon and such. However, it is only within the very last decade or so that we have been able to obtain the various members of the group in quantity and to study them in real earnest. Already we are learning that we are dealing with a new dimension of therapy and man controllable changes in several exciting areas of human endeavor.

The individual animal organism manufactures (and uses almost instantly) prostaglandins in almost all cells at the real basic, molecular level. Most fundamentally, these compounds seem to help regulate intra-cellular concentrations of cyclic AMP. This must concern RNA and protein synthesis, to say nothing of ^{32}P incorporation into ATP. How much more basic can one get? All this serves to underscore the abysmal ignorance we sagely disguise as "biochemical progress."

In trauma and shock, in *abortion*, nasal congestion, peptic ulcers, asthma, hypertension — you name the condition — the prostaglandins are shown as being vitally involved. Just think of inserting a vaginal tampon with a trace of the needed prostaglandin—abortion within hours, spontaneously and without any risk and almost at no expense! Can there be better population control?

The monograph is not too tough on the patient reader. I can recommend it unreservedly, especially to the younger colleagues who are the wave of the future.

ARNOLD LIEBERMAN, M.D.
New York

ATHEROSCLEROSIS

Proceedings of the Second International Symposium held in Chicago Nov. 1969, Springer-Verlag, Edited by Richard Jones; 705 pages with innumerable illustrations and tables; $18.00.

This volume is truly a gourmet's delight. It recalls that old and still famous definition of a skirt length: "long enough to cover all points of importance; short enough to be interesting."

Many complex and still evolving topics are presented in a most readable and truly understandable fashion concisely and precisely. Even the coining of a new word, "insudation," can be pardoned as it is clearly the opposite of "exudation." The HOW of lipid deposition in the elastin of fragmented membranes is explained in the simplest terms conceivable. Autoimmune hyperlipidemia in immunized animals is made explicable. The role of the prostaglandins is gone into as far as possible (for today). I could go on and on. For just one item—the positional specificity of "lipoprotein lipase" was analyzed in terms useful to the reader who heard of the item for the first time.

The paper, binding and printing are absolutely superb. No wonder the entire work had to be subsidized to make possible the almost ridiculously low price. Congratulations to Dr. Louis Katz (the chairman of the symposium) and all the workers who made this monograph such a rewarding experience!

ARNOLD LIEBERMAN, M.D.
New York

RESPIRATION AND CIRCULATION

One of a series of Handbooks sponsored by FASEB (Federation of Am. Societies for Experimental Biology), compiled and edited by P.L. Altman and Dorothy Dittmer, Bethesda, Md., 11 sections, 902 pages, innumerable tables, hundreds of contributors, massive bibliography, 1971; $30.00.

This massive tome does not bury information; it makes it available for the one who seeks. This, in itself, is an achievement for which Dr. Raymund Zwemer, the chairman of the committee, and his able staff deserve much kudos. Spot checking, I saw no errors and picked up a great deal of esoterica plus the expected solid factual knowledge.

Even some of the unusual was intriguing. Thus, on page 230, I came across the Ponderal Index. It was a new word to me. Of course, "ponderous" comes from same root; it means having weight. This index takes into account the height and weight of the individual in conjunction with the weights of the muscles of the right and left sides of the heart. The index comes up with a figure that expresses the normal as against various disease states. Quite interesting; it may have practical clinical significance.

The paper and printing are superb; the binding could be better. At the modest price of only $30 this volume becomes a must for

hospital and medical school libraries. No wonder that it had to be heavily subsidized.

ARNOLD LIEBERMAN, M.D.
New York

MOLECULAR PROPERTIES OF FRUG RECEPTORS

Ciba Foundation Symposium—edited by Ruth Porter and Maeve O'Connor—J.&A. Churchill, London, England, 1970, 298 pages with numerous tables and illustrations; $12.50.

The usual score or so of eminent specialists on this particular frontier of research held a long and earnest colloqium as to just exactly *HOW* neuro-transmission takes place on the molecular tridimensional level.

The topic of alpha and beta receptors and antagonists is being pursued further into the stereoisomeric molecular shapes of agonists and *anta*gonists; what and which ligand does just how and where; what are the active sites of the lysozomes; just how *do* the receptors in the post synaptic membrane of the motor end plate function: just what are the conformational transitions in the course of membrane excitation: the still dimly discerned, mist enshrouded, of memory imprinting molecule intertwining—confusing termins but steadily becoming more comprehensible.

Still veiled in the mists of the future, we are being hand led into and up to heights which begin to give us glimpses of the future. It is stimulating even if still incomprehensible to such M.D.s as you and I.

As usual, the printing, binding and paper cannot be faulted. I look wistfully to the day when such a symposium can be written down to a more comprehensible level.

ARNOLD LIEBERMAN, M.D.
New York

Abstracts from Various Literature, Prepared by AMA

FIBROMYOMATA OF UTERUS WITH HEMOTHORAX—MEIGS' SYNDROME?

S. Solomon (755 Park Ave., New York 10021), S. A. Farber, and L. J. Caruso.

Arch. Intern. Med. 127:307-309 (Feb.) 1971.

Meigs' syndrome is a condition in which certain benign tumors of the ovary are accompanied by ascites and hydrothorax, an association resembling carcinoma with metastases. However, after removal of the tumor the patient is cured and the effusions absorb spontaneously. Two patients with fibromyomata of the uterus and hemothorax which disappeared following hysterectomy are reported. Meigs did not include benign tumors of the uterus in his writings on the syndrome that bears his name. Salmon was the first to do this. It seems awkward, however, to devise a totally new name (Salmon's syndrome) for what is really a variation of a familiar condition. It is proposed that the definition of the syndrome be broadened to include all benign tumors of the female pelvis with pleural effusion (as Salmon defined it) since the treatment and prognosis are the same. If this is done, then logically the name should be modified to Meigs-Salmon syndrome.

CAROTID ARTERY OBSTRUCTION FOLLOWING LSD CAPSULE INGESTION

J. Sobel (Coney Island Hosp., Brooklyn, N.Y. 11235), O. E. Espinas and S. A. Friedman.

Arch. Intern. Med. 127:290-291 (Feb.) 1971.

After the ingestion of capsules said to contain LSD, a 14-year-old boy developed focal neurologic changes associated with obstruction of an internal carotid artery. Physicians should be alert to probable serious vasospastic effects of some encapsulated illicit drugs. There may be an etiologic relationship between LSD and arterial obstruction.

PERSONALITY FACTORS IN MARIJUANA USE

N. Q. Brill, E. Crumpton, (UCLA Medical Center, Los Angeles 90024) and H. M. Grayson.

Arch. Gen. Psychiat. 24:163-165 (Feb.) 1971.

Four groups of marijuana users differing in extent of use (from less than once a month to almost every day) were compared with two control groups (non-users and subjects who had tried marijuana without continuing to use it) on four Minnesota Multiphasic Psychiatric Inventory scales, a risk-taking propensity scale, stimulus-seeking scale, nine specially constructed items, and a number of demographic variables. More frequent use of marijuana was significantly related to higher scores on the stimulus-seeking scale, on the MMPI Pd scale, and to "true" responses to the two items "a person should not be punished for breaking a law that he thinks is unreasonable" and "as long as I can remember, I have had more emotional problems than other people." Regular use of marijuana was significantly related to use of other drugs.

CHROMOSOME EXAMINATIONS IN PATIENTS ON LITHIUM CARBONATE

L. F. Jarvik et al. (722 W. 168 St., New York 10032)

Arch. Gen. Psychiat. 24:166-168 (Feb.) 1971.

Because of a report in the literature that three patients on lithium carbonate showed chromosone damage in excess of that seen in controls, peripheral blood cultures were set up from 16 manic-depressive patients who had taken lithium carbonate for periods of two weeks to over two years (eight of them for one year or more), from four manic-depressive patients on placebo, and from ten control subjects. Even though the highest frequency of breaks occurred in the lithium group (3.3%), the value corresponded to the means (1.9% to 4.3%) generally observed in the laboratory and the difference between the lithium group and the present controls (1.5% breaks) did not reach statistical significance.

ENZYME SENSITIZATION IN CONSUMERS OF ENZYME-CONTAINING WASHING POWDER

L. Belin et al. (Institute of Micro-biology, Goteberg, Sweden)

Lancet 2:1153-1157 (Dec. 5) 1970.

Adverse reactions in the eyes or airways in connection with the use of enzyme-containing washing powder are described in three female consumers. Prick tests resulted in immediate skin reactions to test enzyme solutions in concentrations which do not give nonspecific weal reactions. Circulating IgE antibodies to the enzyme were also demonstrated. Information about the sensitizing allergen in the enzyme preparation was obtained by skin testing with fractions of the gel-filtered and electrophoretically separated enzyme preparation (Alcalase). The antigenicity of the enzyme preparation was tested by parenteral immunization of a rabbit. These analyses indicated that the allergen was immunogenic in the rabbit and, furthermore, it was identical with the main enzymatically active fractions obtained by gel filtration and electrophoresis. The danger of sensitization is not restricted to employees manufacturing enzyme-containing washing powder but may arise in every situation where these enzymes may be present as dust particles.

CLINICAL SPECTRUM OF PLAGUE IN VIETNAM

C. G. Reiley (1207 Fairchild Ct. Woodland, Calif. 95695) and E. G. Kates.

Arch. Intern. Med. 126:990-994 (Dec.) 1970.

The Republic of Vietnam is highly endemic for plague infections. With the volume and efficiency of air travel, this disease may occur in servicemen or civilians who return from this area. There was a wide spectrum of manifestations in six cases of proved and two of presumptive plague infection in patients hospitalized in the US Army Eighth Field Hospital. These cases occurred in persons of varied ethnic background. The features of the classic fatal bubonic-septicemic form were seen, as were cases difficult to distinguish from lymphogranuloma venereum. Treatment was effective in all but two cases. Continued awareness of this disease is emphasized.

GROSS COMPOSITION OF WEIGHT LOSS IN OBESE MEN ON 400-CALORIE DIET

T. H. Allen (USAF School of Aerospace Medicine, Brooks AFB, Texas 78235) and P. W. Musgrave

Amer. J. Clin. Nutr. 24:14-19 (Jan.) 1971.

Twenty-four obese men were placed on 400-calorie Musgrave diets consisting of 14 gm of carbohydrates, 45 gm of protein, 11 gm of fat, and unlimited amount of low-calorie salads. Although a few lost considerably less fat than others, the mean daily energy supplied from body fat was calculated to have been 1,900 kcal. To this, add approximately 400 kcal metabolizable from the diet and the total daily energy expenditure for these obese men would have been equivalent to 2,300 kcal.

MALIGNANT HYPERPYREXIAL DEATHS IN A FAMILY

M. B. Barlow (Coronation Hosp., Johannesburg, South Africa) and H. Isaacs

Brit. J. Anaesth. 42:1072-1076 (Dec.) 1970.

Three fatal cases of malignant hyperpyrexia occurring in a family are presented. The genetic aspects of this disorder may reside in abnormally high serum creatine phosphokinase, present in many healthy relatives of these patients.

ELECTRICAL SHOCK HAZARDS: PART I

P. E. Stanley (Purdue Univ., Lafayette, Ind. 47901)

Hospitals 45:58-63 (Jan. 1) 1971.

Electric shock hazards are defined in terms of macroshock and microshock cases. Five to 10 milliamperes flowing arm-to-arm or in other ways through the patient can produce undesirable reactions. One hundred milliamperes for one second can be fatal, as can 10 microamperes flowing through a conductor placed inside the heart to a terminal on the body surface. Both the building wiring and the equipment used, as well as the way in which they are used, can contribute to the generation of hazardous currents.

ELECTRICAL SHOCK HAZARDS: PART II

P. E. Stanley (Purdue Univ., Lafayette, Ind. 47901)

Hospitals 45:73-80 (Jan. 16) 1971.

The objective of any electrical safety program is to prevent accidental shocking of patients or personnel. Patient safety is provided primarily by a ground system of high integrity, but additional precautions, such as the installation of isolated or ungrounded systems and equipment that meet the specification of low-leakage currents and high-impedance inputs, may be required. Careful testing and maintenance programs aid in ensuring the safe operation of the entire electromedical system.

RENAL ARTERIOGRAPHY IN ASSESSMENT OF RENAL TRAUMA

E. K. Lang et al. (Louisiana State Univ. School of Medicine, Shreveport 71105)

Radiology 98:103-112 (Jan.) 1971.

Selective renal arteriography allows more definitive assessment of renal trauma by demonstrating ischemic changes in the surrounding parenchyma or indicating a siphoning effect from arteriovenous fistulae. Renal angiography combined with clinical examination and excretory urography is advocated for the evaluation of blunt or penetrating renal injury.

"RESPIRATOR LUNG": A MISNOMER

G. Nash (Massachusetts General Hosp., Boston 02114), J. A. Bowen, and P. C. Langlinais

Arch. Path. 91:234-240 (March) 1971.

Light and electron microscopic observations were made on the lungs of adult angora goats which breathed 100% oxygen or room air with and without mechanical positive-pressure ventilation. All animals treated with 100% oxygen were killed in extremis or died spontaneously within four days. All animals breathing air remained well and were killed within two weeks. In animals exposed to 100% oxygen no differences were found between those treated with and without a mechanical ventilator. All animals exposed to room air had normal lungs whether or not a mechanical ventilator was used. The evidence presented supports the contention that mechanical positive-pressure ventilation, a physiologic inspiratory pressure, does not in and of itself cause morphologic pulmonary alterations.

MYASTHENIA GRAVIS APPEARING AFTER REMOVAL OF THYMOMA

M. S. Azer (VA Hosp., Clarksburg, W. Va. 26301), E. Zikria, and W. B. Ford

Amer. Surg. 37:109-113 (Feb.) 1971.

Of particular interest are the paradoxical case reports of removal of thymona in patients who were free of myasthenia gravis and who developed the symptoms at varying intervals after operation. This is a report of one such case and a review of all cases published in the medical literature. The exact relation between thymoma and myasthenia gravis still remains unsolved; both could have a common eitologic factor which is unknown so far.

ENDOGENOUS HYPERLIPIDEMIA INDUCED BY EMOTIONAL STRESS OF RACING DRIVING

P. Taggart (Middlesex Hosp., London) and M. Carruthers

Lancet 1:363-366 (Feb. 20) 1971.

Plasma samples have been taken from racing drivers at various times within a three-hour period following a race. The samples were analyzed for levarterenol, epinephrine, free fatty acids, triglycerides, and cholesterol. Racing driving was chosen to provide an example of an extreme emotional and aggressive situation, associated with minimal physical effort, which might be expected to demonstrate magnification of certain biochemical changes that may occur in everyday life. The total catechloamine levels were grossly elevated, the increase being largely due to levarterenol. The FFA levels were also elevated one to three minutes before the start while the drivers were on the starting grid, and up to one hour after the race. The triglyceride levels were slightly elevated after the event, continued to increase, and reached a peak at one hour. An exciting stimulus such as fast competitive driving can temporarily raise the plasma levels of FFA and triglycerides, two substances indicated in the cause of atheroma.

PREGNANCY OUTCOME FOLLOWING ORAL CONTRACEPTIVES

S. C. Robinson (5580 Spring Garden Rd., Halifax, Nova Scotia)
Amer. J. Obstet. Gynec. 109:354-358 (Feb. 1) 1971.

One thousand two hundred fifty births occurring in women who had previously used oral estrogen-progestin contraceptives were paired with 1,250 control births, matched for age and parity, occurring in nonusers of oral contraceptives. A detailed examination of the fetal outcome was made under rigid conditions in one neonatal unit. Analysis of the offspring does not show a statistically significant difference in the frequency of abnormalities in the two groups.

PROPHYLACTIC REGIONAL LYMPH NODE EXCISION IN MALIGNANT MELANOMA

J. Abu-Dalu et al. (Tel-Aviv Univ. Medical School, Tel-Aviv, Israel)
Harefuah 80:128-130 (Feb. 1) 1971.

Prior to 1962 patients with malignant melanoma were treated by wide, local excision of the primary growth and by skin grafting; regional lymph nodes (axillary or inguinal) were excised only when found enlarged. The overall five-year survival rate in 44 such patients was 25%. Since 1962 the authors have performed prophylactic excision of the regional lymph nodes in addition to local excision of the melanoma. This second series includes 80 patients; 40 of them have been followed for at least five years. The overall survival rate in this group was 62.5%, 48% in those with positive lymph nodes and 81% in those with negative nodes.

CONTROLLED TRIAL OF FLUORIDE IN VITAMIN DROPS FOR PREVENTION OF CARIES IN CHILDREN

L. Hamberg (Stockholm City Child Welfare Centers, Stockholm)
Lancet 1:441 (Feb. 27) 1971.

Seven hundred and five children took part in a controlled trial in which they were given vitamin A and D drops routinely supplied by Swedish child-welfare centers with or without supplement of sodium fluoride. The children were examined by a dentist each year from the age of 1 to 6 years or longer. At the third, fourth, fifth and sixth examinations, the mean number of decayed teeth was around 50% lower in the fluoride group. It is recommended that fluoride be given in vitamin drops where the local fluoride content of drinking water is below 0.6 ppm.

REVERSIBILITY OF MALIGNANT HYPERTENSION

G. Pickering (Pembroke College, Oxford, England)
Lancet 1:413-417 (Feb. 27) 1971.

Three patients who had extremely high arterial pressure, fully developed neuroretinopathy and arteriolar necrosis in kidneys and adrenals are described. Arterial pressure was reduced in all patients by surgery, retinopathy was resolved and the patients survived for six years. Primary lesion was pyelonephritis in all three patients. One patient died of cerebral hemorrhage, possibly from a Charcot-Bouchard aneurysm, after nine years. Two patients survived 24 years after the malignant phase, one having had a myocardial infarct at age 37. Where pressure is reduced, the fibrinoid deposit in the arterial wall is quickly reabsorbed. These case histories show that when the pressure remains only moderately elevated, fibrinoid necrosis of arterioles does not recur, at least in 24 years. ◄

Pre-Sate® (chlorphentermine hydrochloride)

Caution: Federal law prohibits dispensing without prescription.

Indications
Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (i.e. several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.

Contraindications
Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.

Warnings
When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.
Drug Dependence Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with the high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.
Usage In Pregnancy The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.
Usage In Children Not recommended for use in children under 12 years of age.

Precautions
In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorectic agent and a restrictive dietary regimen.

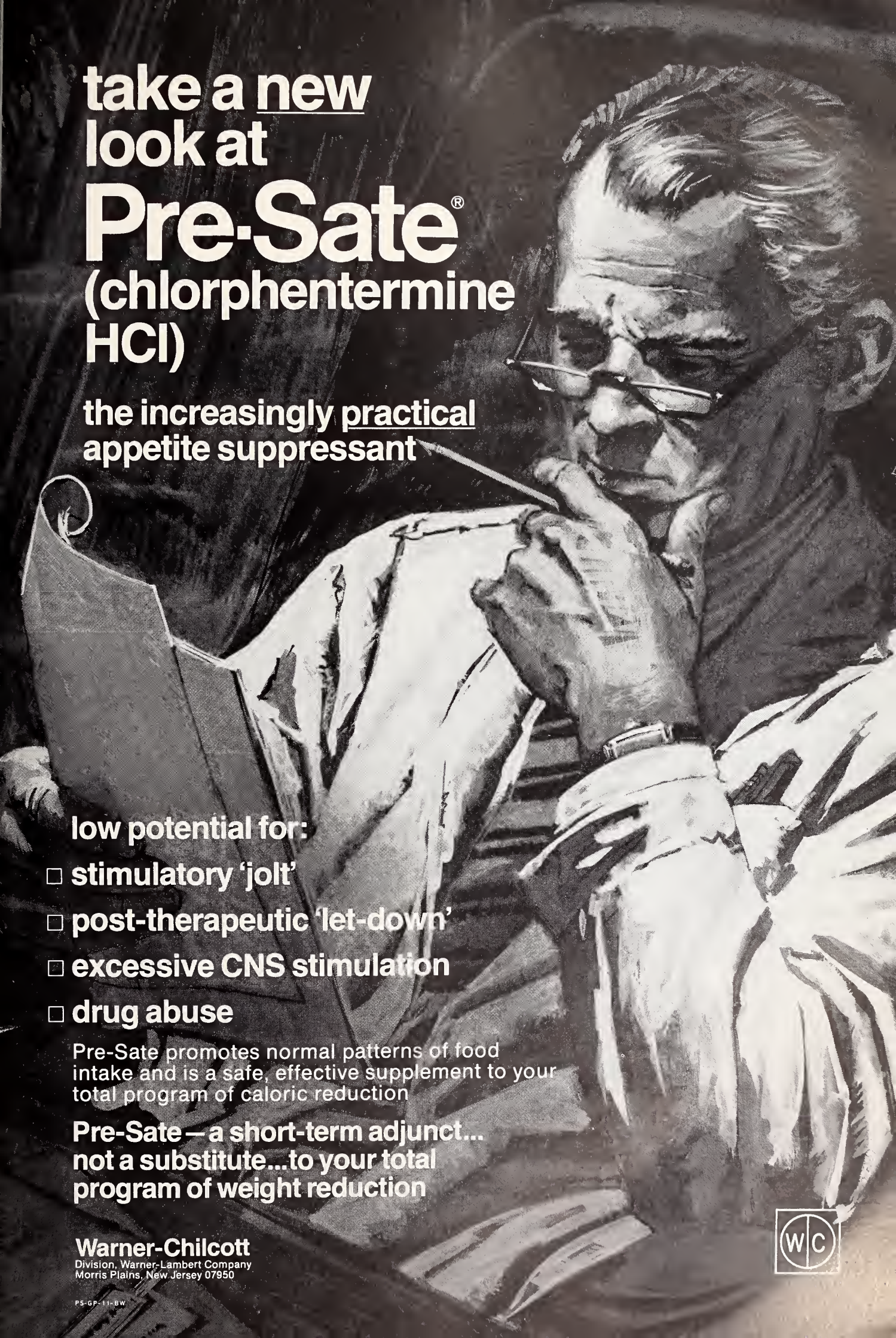
Adverse Reactions
Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.

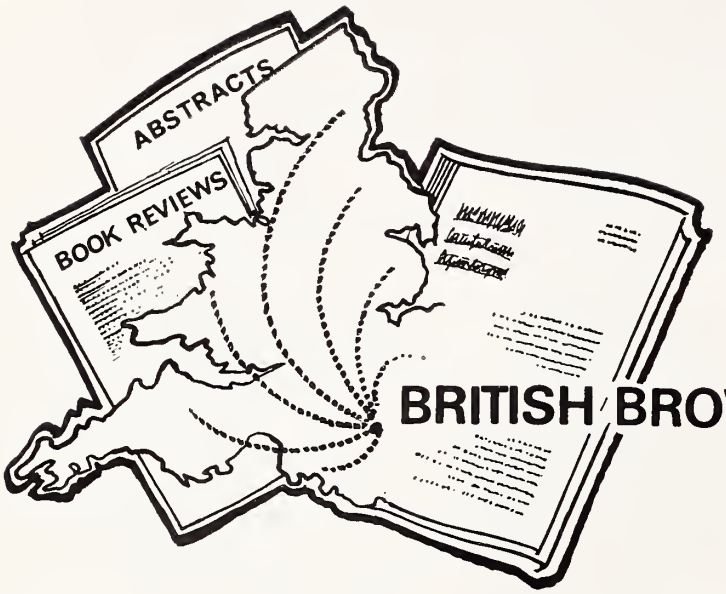
Dosage and Administration
The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.

Overdosage
Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.
Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

How Supplied
Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.

Full information is available on request.


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BRITISH BROWSINGS

STEVEN C. BEERING, M.D.
Indianapolis

Further Experience with Prolonged Therapeutic Starvation in Gross Refractory Obesity

HAVING struggled for years in attempting to aid patients to achieve a more desirable weight, my attention was naturally attracted to the interesting article by Munro and others[1] concerning their further experiences with prolonged therapeutic starvation for gross obesity in a hospital setting. There were 25 patients ranging in age from 16 through 53, comprising a group of 11 men and 14 women. All of them were better than 50% over their ideal weight. It was the objective of the fast to come within 25% of the ideal body weight. The fast lasted from 4 through 196 days with two of the patients discharging themselves from the study in the early weeks of the program while four others refused follow-up upon discharge. In addition, 7 patients were discharged from the study for psychological or social reasons when they began to regain weight while on the fast. This left 12 patients who were discharged weighing no more than 25% in excess of their ideal body weight. Alas, four of these regained a significant amount of weight, leaving but eight near their discharge weight at the time of follow-up—namely, three, six and 18 months later.

Most patients tolerated the period of starvation nicely. However, two developed symptoms attributable to hypotension and hypokalemia which were so severe in one patient as to necessitate temporary discontinuation of starvation. One patient developed an attack of clinical gout. Two other patients developed temporary hair loss and two requested cosmetic surgery for unsightly skin folds.

In summary, therapeutic starvation was successful in 8 of 25 patients who agreed to fast for periods averaging 100 days in the hospital and who managed to maintain their discharge weights within 25% of their ideal body weight for a period of a year and a half.

Restless Legs Sydrome

Two articles in the December 26, 1970, issue of the *British Medical Journal* point to the presence of the interesting and frustrating diagnosis of restless legs in 35 patients with gastric surgery, diabetes mellitus or uremia and a group of patients having chronic pulmonary disease.[2,3]

The restless legs syndrome was first described by Thomas Willis in 1685 as follows: "Wherefore to some, when being a Bed they betake themselves to sleep, present in the Arms and Leggs Leapings and Contractions of the Tendons, and so great a Restlessness and Tossings of their Members ensue, that the diseased are no more able to sleep, than if they were in a Place of the greatest Torture." Other authors have described it as "anxietas tibiarum" (Wittmaack, 1861), "leg jitters" (Allison, 1943), and "asthenia crurum paraesthetica" (Ekbom, 1944). It was Ekbom's several articles in 1944 and 1945 which recalled the interesting syndrome and consequently a number of more recent publications have named it the Ekbom Syndrome.

Drs. Banerji and Hurwitz felt that the following four questions answered in the affirmative are diagnostic of the syndrome:

1. Do you have any unpleasant feelings in the legs which keep you from sleeping?
2. Is the unpleasant feeling completely relieved by walking about?
3. Do you have to move your legs when you have the feeling?
4. Does it appear on going to bed at night or sitting in the evenings?

All of the 35 patients the authors described had difficulty in getting to sleep because of their restless legs and had an irresistible desire to move their legs about. The duration of the

sensation at night varied from 10 minutes to six hours and did not necessarily occur every night. Some of the patients were troubled with the restless feeling when they sat down during the daytime, especially toward evening. There were 10 patients who also complained of tiredness and a feeling of weakness.

The guesses as to etiology of the restless legs syndrome are many and varied. Anxiety has been suggested by most authors since thorough study usually does not reveal any vascular, neurologic, bony or muscular abnormality. It is of some interest that in both of the series reported here the men predominate.

The one common feature present in all reported series is the presence of a chronic or debilitating disease which very reasonably may result in this psychosomatic manifestation of a depressive reaction.

Curiosa et Exotica

In a delightful article, Dr. William St. C. Symmers[4] describes 18 vignettes from his many years of practice as a pathologist. The several paragraphs that follow are worth quoting as they bring to mind many similar stories about the National Health Service in Great Britain.

"A man of 21 wanted to join a famous police force. He had a right inguinal hernia and was told that it must be cured surgically before he could be enrolled. His family doctor accordingly arranged for him to be seen at hospital. The hospital could not give him a consultation appointment until two months later. At the end of this time he was duly seen by a surgeon, and his name was put on the waiting list for admission - he was told he could expect a bed in about four to five months. After six months had gone by without word he inquired about the chances of early admission; he was told he would have to wait at least another three months as renovation of the wards was holding up non-urgent admissions.

"Four more months passed without news. The patient then made more inquiries at the hospital. This time he was told he would have to wait at least three months longer as the operating theatres were being rebuilt and only emergency cases could be admitted for surgery. The three months went by and then he insisted on speaking again to the surgeon in person. The surgeon promised to look into the delay, and two months later his registrar wrote to the patient to let him know he could expect to be admitted "some time after July." This letter was written in February; it did not specify which July, or how long after July admission might be expected. As 17 months had already passed since his doctor had first got in touch with the hospital to try to arrange for the operation, the patient wrote to his Member of Parliament to see if he could have anything done to expedite the operation. Two months later the M.P. wrote back, expressing warm sympathy and assuring his constituent that searching inquiries had confirmed that everything possible had been done to hasten his progress to recovery.

"July of that year came and passed, and there was still no word of a bed. His doctor reluctantly agreed to refer him, at his own request, to the surgeon as a private patient. A week after the resulting consultation, which took place promptly, the patient was admitted to a public ward in the hospital for his herniorrhaphy. He understood that the operation was to be done by the surgeon whose consultation fee he had paid, but it was the surgeon's registrar who operated and removed his appendix, which was normal. The mistake was recognized when the registrar operated on the next patient on the list, expecting to do a right inguinal herniorrhaphy but finding no hernia and instead having to remove a kinked and fibrotic appendix.

"Four days later the surgeon who had arranged the patient's admission repaired the hernia himself, and left a gauze wipe in the wound. A persistent sinus resulted, the cause of which was discovered five months later. The outcome was a large and unsightly scar, and recurrence of the hernia. A year after the first operation the patient was operated on again, by the same firm, this time successfully and without complications. He was then 24 years old, over the age limit for enrollment in the force he had wanted to join."

I guess this proves that all problems eventually find a solution if one but waits long enough.

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The Woman's Auxiliary

REPORTS TO ISMA

May was a busy month in Indianapolis. We had the NATO Conference of Mayors as well as the 500-mile race. A number of doctors' wives worked with many others to help make the conference a success. A few doctors' wives from all over the state attended the conference.



The "Think In" for all the County presidents and chairmen was also held in May and was a big success. We were fortunate to have a national representive, Mrs. Virginia Stoltz, president of the national Medical Auxiliary in 1963. Mrs. Stoltz is from South Dakota. She spoke on the importance of being a member of the Medical Auxiliary. She suggested that the auxiliary take part in community activities, that as active members of a group they had a more forceful and united voice. A doctors' wife is a walking commercial for medicine. She should be a talking commercial, Mrs. Stoltz said. Please encourage your wife to join her local auxiliary.

Dr. Malcolm Scamahorn was the luncheon speaker. He suggested ways to make life a little easier for our husbands. We were pleased to have seven of our state chairmen present suggestions on projects and activities that can be done at the county level. We hope the enthusiasm generated that day will be taken back to each county.

I mentioned in my first article that we would have guest writers from time to time. This month it is Mrs. Herbert Egbert. Mildred is the faithful liaison officer for WA-SAMA. She does a wonderful job which is attested to by the enthusiasm of the girls she works with. Mildred will tell you a little bit about WA-SAMA and what they do.

Lelia M. Chernish

WA-SAMA What Is It?

WA-SAMA is not a Japanese radio. It is the **W**oman's **A**uxiliary to the **S**tudent **A**merican **M**edical **A**ssociation. It is a national organization of wives of medical students, interns, residents, fellows and military doctors. In Indiana it is a group of around 100 wives of medical students at the IU Medical School.

WA-SAMA was founded in 1957 under the sponsorship of the Student Medical Association (SAMA) and the Woman's Auxiliary to the AMA (WA-AMA). It has more than 70 chapters and about 5,000 members.

The national WA-SAMA serves as an information relay center through its newsletter, "Chatterbox," and it arranges an annual convention where delegates discuss ideas and problems.

Seven territorial regions provide closer contact. The Indiana chapter of WA-SAMA was host last April to delegates from the seven states of Region IV. Emerson Hall buzzed with sessions on programs, service and projects. Doctors' homes graciously housed the delegates.

WA-SAMA's purpose is to assist the wives while they are helping their husbands through medical school. Wives see others who have long, lonely hours and who manage jobs, housekeeping and children on tight budgets. They make friends and find help in housing, job hunting and baby-sitting.

Another purpose is to help WA-SAMA members get acquainted with the medical community and medical practice. The student wives know Medical Auxiliary members and attend some of their meetings. For several years one of the most popular WA-SAMA programs was a panel of doctors' wives. Questions included "How do you keep a meal warm for four hours?" "How do you get your husband to notice when you're sick?" and "What is wrong with socialized medicine?" Panel members answered candidly all questions, from personal problems to medical ethics.

Monthly meetings of WA-SAMA offer social or informative programs, according to members' requests. Interest groups offer bridge, hobbies and recreation.

WA-SAMA members are capable, thinking young women who also are interested in community service. They have adopted an elderly lady for a year, given hours of work to Riley Hospital and helped the inner-city clinics where some of their husbands volunteer.

The local chapter raises its funds by various projects, including rummage sales, car washes and birthday cake delivery. A big but worthwhile expense is postage for the monthly newsletter, "Epidemic." The State Medical Auxiliary allots money each year to the IU WA-SAMA to send delegates and the liaison to the regional and national conventions. Many individual Auxiliary members through the state give $5 for a sustaining membership to the national WA-SAMA.

The Indiana State Auxiliary appoints a liaison to WA-SAMA each year. With the help of two other Auxiliary members, she attends all WA-SAMA meetings and board meetings, finds homes for meetings, assists with programs when asked, reports on WA-AMA work and helps wherever needed.

I am happy to report that medical students and wives are not all irresponsible or "hippy," in spite of a little more hair. Most are working hard, just like medical students of former days, except that they might have more to learn and more complex problems to face. Also, the wives might seem younger and cuter as we mature?

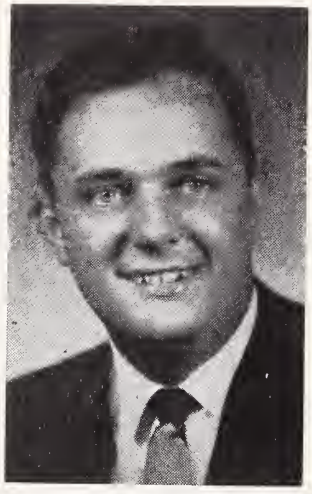
The Medical Society and Auxiliary can enjoy and benefit from contact with the students, just as they need the Medical Society. Together we all can work to continue good medical care.

Mildred Egbert
Liaison to WA-SAMA

Your Blue Shield Professional Relations Staff

THE Indiana Blue Shield Professional Relations External staff has been expanded, and is providing greater service to physicians of Indiana and their medical assistants by solving problems and furnishing information with regard to Blue Shield.

Eight persons who comprise the External staff are a part of a total of 25 people in the department, contrasted with only two men and one secretary three years ago. Assisting the head of the staff is a field manager and six field representatives.



H. P. Dixon
Vice President



G. R. Miller
Field Manager

Their program includes educational services through informing physicians and their office staffs about Blue Shield, and through the distribution of a doctor's assistant's handbook.

The staff also handles inquiries from physicians, such as claim problems; explains and adjudicates usual and customary programs and utilization review.

Other parts of the program include conducting miscellaneous investigations, attending various meetings, conventions and seminars, as well as furnishing any other form of assistance needed. The annual two-day Blue Shield seminar was held recently in Indianapolis.

Every field representative not only possesses a complete knowledge of Blue Shield information, but is involved with all relations of a physician in aspects of health care.

Professional Relations has recently concluded 134 two-hour workshops for doctor's assistants and this fall will hold 24 dinner workshops for medical assistants.

One of the most important Professional Relations developments of the past year is the use of data processing to aid utilization review. Patterns of practice are researched with respect to utilization, abnormalities of service and relationships of practice within a given area. This computerized program links together Blue Shield and the medical profession and forms a responsible, workable solution to the rare instances of abuse and impropriety within the health care field.

Those who normally call long distance to Blue Shield Professional Relations may use the WATS line number, 800-382-1600, at no charge. Local callers in the Indianapolis metropolitan area should dial 636-6581.

Heading the Professional Relations staff is Herbert P. Dixon, vice president, who has been with Blue Shield for seven years. Mr. Dixon attended Wabash College and is a Butler University graduate with an A.B. in political science and an M.S. in administration. He was recently elected to the board of trustees of the Butler Alumni Association.

Field manager in charge of representatives who work directly with physicians and their offices is Gary R. Miller, who has been with Blue Shield for three and one-half years. A graduate of Butler University, he has a B.S. degree in radio and television.

Mr. Dixon and Mr. Miller normally handle departmental planning, medical society meetings, district society meetings, hospital staff meetings, Blue Shield seminars and district advisory council meetings.

The field staff includes two representatives who cover the entire state, specializing in government contract work, plus four representatives who service a specific area.

Jack Byrne, a registered pharmacist, calls on pharmacists and dentists and allied professions thorughout Indiana. He owned and operated a drug store in Greenfield for 18 years prior to joining Blue Shield. In addition to his field duties, he presents a series of Blue Shield lectures to fifth year students in the pharmacy school at Purdue.

Jerry Waid, formerly a supervisor in Medicaid, meets with optometrists, medical supply dealers, ambulance providers and dentists in his work throughout the state. Mr. Waid also lectures to optometry students at Indiana University. He attended Indiana Central College.

Phil Sizelove, the newest field representative, is assigned the northwest Indiana region. He is a Ball State university graduate and majored in business administration.

Jerry Martin, who has been with Blue Shield for one year, covers the northeastern Indiana territory. A Navy veteran, he is a graduate of Indiana University with a B.A. in chemistry.

Beverly McGraw, a registered nurse and the first woman field representative, has the central Indiana district plus extensive activity with medical assistants and their state organizations. She is a graduate of Ball State and worked in a doctor's office for 18 years.

Tom Erwin calls on southern Indiana physicians. A Navy veteran, he was in Medicare for two years before joining Professional Relations. He has lectured at the Bryman School for Medical Assistants in Indianapolis and MA classes at Ivy Tech, along with field manager Gary Miller.

Comprising the secretarial staff for Professional Relations are Miss Linda Buis, secretary to Mr. Dixon; Mrs. Barbara Hamilton, secretary to Mr. Miller; and Miss Debbie Noah, field secretary.

FIELD REPRESENTATIVES

Jack Byrne ....Statewide
Jerry Waid ....Statewide
Phil Sizelove ..Northwest
Jerry Martin ..Northeast
Beverly McGraw..Central
Tom Erwin .....Southern



Jack Byrne



Jerry Waid



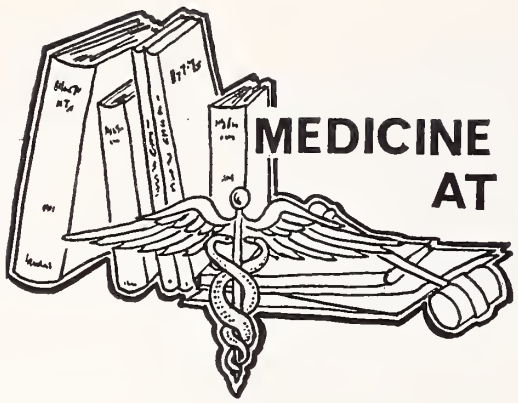






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1. Phil Sizelove
2. Jerry Martin
3. Beverly McGraw
4. Tom Erwin



Smoking in Oxygen Tent Due to Patient's Fault—A hospital has no duty to search the purse of a patient in an oxygen tent, a New York appellate court ruled.

A female patient was placed in an oxygen tent. She was alert and in control of her faculties. On several occasions she was warned of the dangers of smoking in an oxygen tent. A fire occurred and the patient died.

The administratrix of the patient's estate filed a lawsuit against the hospital. The administratrix claimed that the patient had been permitted to wear a silk nightgown when placed in the oxygen tent. She contended that a spark of static electricity caused the fire.

At trial, the patient's physician, the head nurse and a practical nurse all testified that the patient had worn a hospital gown. The hospital records indicated that, after the patient's death, a silk nightgown was returned to her daughter.

A patient who had been in the same room testified for the hospital. She said that, prior to the fire, she heard the deceased patient open her drawer, and then her purse. The evidence indicated that all cigarettes and matches had been removed from the deceased patient's nightstand before the fire. After the fire, charred matches were found in the oxygen tent.

Judgment was entered in favor of the hospital, and the administratrix appealed.

Affirming the decision, the appellate court said that the evidence strongly favored the hospital. The patient was alert and in control of her faculties, the court noted. She had been warned on several occasions of the dangers of smoking in an oxygen tent. The hospital had no duty to search her purse for cigarettes and matches, the court ruled.—*Evans v. Newark - Wayne Community Hospital, Inc.*, 316 N.Y.S.2d 447 (N.Y. Sup.Ct., App. Div., Dec. 10, 1970).

Stipends of Intern Not a Fellowship—A hospital intern's exclusion of $3,600 from his gross income on the basis that the payments were a fellowship was denied by the United States Tax Court.

The payments by the hospital were to be considered compensation for the care of patients, rather than for the education of the intern, according to the Tax Court. This was evidenced by the fact that he was eligible for a paid vacation and that his stipend depended on the length of service. Thus, the stipend represented payment for services and must be included in the intern's gross income.—*Anderson v. Commissioner*, 54 T.C., No. 148 (July 28, 1970).

Physician Guilty in Deaths from Sodium Pentothal Injections—A physician was properly found guilty of involuntary manslaughter where it was shown that sodium pentothal was injected in excessive amounts, a Michigan appellate court ruled. The patient died while being treated at the physician's medical clinic.

After her death blood and tissue analysis revealed high concentrations of sodium pentothal in the blood and brain of the deceased. Expert witnesses at the trial testified that death was caused by a too rapid infusion of an excessive amount of the drug. Other testimony showed that the doctor left the patient unattended during the infusion, that the clinic did not have resuscitative equipment and that the physician's conduct violated accepted medical standards.

The physician was found guilty of involuntary manslaughter. On appeal, he claimed that his medical records of the treatment of the deceased were not returned to him by the police at the time of trial. The appellate court would not reverse th conviction on this ground becaus the physician did not raise a proper objection at the time of trial.

The physician also argued that the complaint filed against him did not sufficiently inform him of the charge. The involuntary manslaughter statute states that negligent acts or omissions are to be included in manslaughter. In the present case, the physician was charged with gross and culpable negligence, and the court concluded that this was sufficient to inform him of the charge.

Finally, the fact that the physician did not object to the admission of evidence during the trial regarding lack of oxygen equipment at the clinic prevented him from raising this argument on appeal, the court held. The evidence presented at the trial, together with the fact that medical students' textbooks, phy-

sicians' manuals and the manufacturer's label on the drug, state the dangers of the drug, support the finding that the physician was guilty of involuntary manslaughter, the court ruled.—*People of the State of Michigan v. Clark*, 182 N.W.2d 632 (Mich.Ct. of App., Sept. 28, 1970; leave to appeal denied, Jan. 22, 1971).

New Kansas Law Defines Death—The first legislative definition of death in the history of the United States and of the common-law world has been enacted by the State of Kansas.

In the past, in individual cases, the law has accepted the medical definition of death as the cessation of all vital signs and has allowed the attending physician to make a determination of death. In practice, the law has required irreversible stoppage of all systems that could be detected and has not accepted the cessation of one vital system as a definition of death.

In 1968, at Harvard, the Ad Hoc Committee to Examine the Definition of Brain Death proposed a new definition of death based on irreversible coma. The clinical recommendations of this committee have since been followed on a worldwide basis.

The Kansas statute, discussed in the medical journal, provided two separate and alternative criteria for determination of death and leaves the determination in the hands of the attending physician.

The first criterion requires that spontaneous respiration and cardiac function be absent and that attempts at resuscitation be hopeless. The time of death is said to be when these functions cease.

According to the second criterion, death occurs when there is evidence that further reasonable attempts to maintain or restore spontaneous circulatory or respiratory function have no hope of succeeding and there is absence of spontaneous brain function. The law further specifies that death is to be pronounced before attempts at resuscitation or supportive maintenance are ended and before any vital organ is removed for transplantation.

The second criterion, which adopted the primary legal recommendation of the Ad Hoc Committee, is without precedent in the law anywhere in the world, the author of the journal article states. The Committee intended it as a means of protecting attending physicians from the accusation of being the last instrument of death when they turned off the heart-lung machine while the person was "legally alive."

The Kansas statute does not require that two physicians pronounce the death. It leaves the determination of various aspects of the definition to the medical profession.—"Legal and Medical Death-Kansas Takes the First Step," by William J. Curran, J.D., 284 *New England Journal of Medicine* No. 5, p. 260 (Feb. 4, 1971), published by the Massachusetts Medical Society, 10 Shattuck, Boston, Massachusetts 02115.

Special Consent not Needed For Extensive Surgery—A patient who contended that the surgery performed on her was more extensive than that for which she had given consent failed to recover damages. Her claim for $200,000 damages was denied by a California jury.

The patient, a 37-year-old housewife, was operated on for a gall-bladder condition. When the surgeon found a large mass on the stomach, he called in another surgeon. The surgeons removed the gall bladder and 70 per cent of the stomach. The mass proved to be a benign gastric ulcer.

The woman brought action against the two physicians, contending that conservative treatment of the ulcer was indicated because it was benign. She claimed that the surgeons should have removed only 30 per cent of the stomach. She also contended that she had not given consent for the removal of 70 per cent of the stomach.

The physicians contended that the condition could have been malignant, since biopsies are sometimes inaccurate. They said that conservative treatment would not have cured the condition because there would have been hemorrhaging if they had removed less of the stomach. They also contended that the general consent of the patient was sufficient.

After the jury brought in a unanimous verdict for the physicians, the patient moved for a new trial.—*Hershaft v. Sherwood* (Ca.Super.Ct. Los Angeles Co., Docket No. WE C8270, 1970).

Physician not Liable for Death Following Penicillin Injection—The widow of a patient who died after receiving an injection of penicillin was denied damages against the physician who administered the injection. A verdict against the widow was handed down by a California jury.

The patient, a 59-year-old executive, was suffering from a sore throat. He was given an injection of penicillin by his physician. The patient died ten minutes later.

The widow sued the physician for $80,000, contending that penicillin was not the proper remedy for her husband's condition. She said that her husband had suffered a bad reaction and that the physician had done nothing to prevent his death.

The physician contended that the husband had suffered a cardiac arrest and that he could have done nothing to prevent his death.—*Peterson v. Blinn* (Cal.Super.Ct., Los Angeles Co., Docket No. EA C7078, 1970).

Osteopath Convicted for not Keeping Drug Records—An osteopath's conviction of violating a federal statute requiring the keeping of records with respect to drugs was upheld by a federal appellate court in Indiana. The osteopath's allegation that his being required to produce the records violated the privilege of self-incrimination under the United States Constitution was rejected.

The statutes of the United States require licensed practitioners to keep a complete record with respect to certain depressant and stimulant drugs. During a three-year period, an osteopathic physician received some 98,100 dosage units of such drugs. A narcotics agent only found 3,780 dosage units during an inventory. No beginning inventory or records regarding the disposition of the drugs could be found.

The osteopath's argument that the recordkeeping requirement violated the privilege against self-incrimination was rejected because the records required were not records of an unlawful activity. Therefore, the statute does not compel the disclosure of a crime.

It was also argued that the criminal action in the federal courts should be dismissed because of a prior conviction in the state court under a similar state statute. This argument was also rejected because the state conviction is not relevant to the federal case. The evidence presented was held sufficient to convict the osteopath.—*U.S. v. Reiff*, 435 F.2d 257 (C.A.7, Nov. 5, 1970); cert. denied, 91 S.Ct. 929 (U.S.Sup. Ct., March 1, 1971).

$500,000 Cardiac Arrest Malpractice Judgment—A $500,000 verdict was returned by a California jury in a surgical cardiac arrest case. The verdict was against the anesthetist and the hospital. No award was made against the surgeon.

A 13-year-old boy was admitted to a hospital for an inguinal hernia operation. A cardiac arrest occurred during surgery, resulting in cerebral anoxia. The boy suffered permanent brain damage and permanent damage to his motor and sensory nervous systems.

At trial, the patient claimed that he was given excessive preoperative medication. He further claimed that the nurse-anesthetist employed by the hospital improperly oxygenated him during surgery and failed to properly monitor his vital signs.

The surgeon, anesthetist and hospital each claimed that the appropriate medical standards had been observed.—*Higgins v. Oroville Community Hospital* (Cal. Super.Ct., San Francisco Co., Docket No. 560411, 1970).

Physician's Restrictive Covenant Valid if "Reasonable"—Whether a restrictive covenant in a physician's partnership agreement is enforceable depends on its reasonableness under the circumstances, a California appellate court held. The covenant in question barred the practice of medicine for three years in a specified portion of a certain county.

A physician who had withdrawn from a partnership sued the remaining partners to recover his partnership interest. The remaining partners had refused to pay him because he opened an office in that area of the county forbidden by the covenant.

The trial court found the restriction invalid on the basis of a state statute in existence at the time the partnership agreement was made. The remaining partners appealed.

Reversing the decision of the trial court, the appellate court said that the statute did not invalidate the covenant in its entirety. Therefore, the trial court was directed to hold further proceedings to determine the reasonableness of the restriction under the circumstances.

The trial court was ordered to consider the effect of the closeness of the withdrawn partner's new office to the partnership office, the population of the areas involved, and whether the withdrawn partner had attracted a substantial number of patients to his new office.—*Roberts v. Pfefer*, 91 Cal.Rptr. 308 (Cal. Ct. of App., Nov. 25, 1970).

Informed Consent in Vein Ligation—In a medical malpractice action in which a patient claimed that her physicians failed to inform her of the number of scars that would result from the ligation of the veins in her right leg a California jury returned a verdict in favor of the physicians.

A woman consulted a general practitioner concerning the veins in her right leg. He determined that it was necessary to ligate the veins and referred the woman to a specialist.

The specialist informed the woman that the ligation would result in many scars. The woman was admitted to a hospital, and the specialist performed a ligation of the greater and lesser saphenous veins in her right leg. As a result of the vein stripping, the woman had 28 scars on her leg.

The woman filed a lawsuit against both the specialist and the general practitioner. She claimed that the physicians failed to obtain her informed consent to the procedure, in that she was not told how many scars would result. No claim was made that either physician violated any standard of care.

The specialist contended that, prior to surgery, it was impossible to determine the number of scars that would result. The jury returned a verdict for both physicians.—*Wells v. Jordan* (Cal.Super.Ct., Sacramento Co., Docket No. 193057, 1970).

Liability for Negligence of Hospital Staff Physician—Whether an emergency patient was referred by the hospital to a staff

physician acting in his "private" capacity or whether the physician was staffing the emergency room as an agent or servant of the hospital was a question for the jury to decide, the Supreme Court of Delaware ruled.

A 16-year-old girl fell and twisted her ankle. When her parents could not reach their family physician, they took the girl to the emergency room of a hospital. The girl's parents told the hospital receptionist that they wanted the physician or surgeon then on duty to care for the girl's injuries.

The hospital's resident physician was not on duty. A staff physician was working in the emergency room at the time. The receptionist told the girl that the staff physician was the surgeon on duty in the emergency room.

After x-rays and an examination, the staff physician applied a cast to the girl's left lower leg from her toes to her knee.

The girl and her parents later filed a malpractice suit against the physician and the hospital. They claimed that the cast was too tight. They contended that as a result of the tight cast, the girl suffered injuries to the vascular, lymph, cellular, and nervous system, tissues and cells of her leg. They further claimed that the hospital was responsible for the negligence of the physician.

The physician and the hospital both denied that he was acting as the agent, servant or employee of the hospital when he treated the girl. The hospital's motion for a summary judgment was sustained by the trial court. The girl and her parents appealed.

Reversing the decision, the appellate court said the question of whether the physician was acting as an employee of the hospital or as an independent contractor was for the jury to decide. Where a staff physician admits his own patient to a hospital and treats the patient in the hospital, the physician is an independent contractor and the hospital is not liable for his malpractice. However, the court said, when a patient is taken to a hospital and treated by a physician employed by the hospital, the hospital is liable for the physician's malpractice.

It was for the jury to decide whether the girl was merely referred to the staff physician in his "private" capacity or whether he was acting as a doctor staffing the emergency facility in the absence of the resident physician, the court held. The fact that the physician was not paid by the hospital is relevant but not conclusive, the court said.—*Vanaman v. Milford Memorial Hospital, Inc.*, 272 A.2d 718 (Del.Sup.Ct., Dec. 21, 1970). ◄

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Please see facing column for summary of contraindications, precautions, and adverse reactions.

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Indications *Male:* Replacement therapy in testicular hormone deficiency states. Prevents atrophy of the accessory male sex organs following castration for as long as therapy is continued. Impotence and male climacteric symptoms when due to androgen deficiency. Primary eunuchoidism and eunuchism. Delayed puberty when established as not a simple familial trait. Indicated for those symptoms of panhypopituitarism related to hypogonadism, however, appropriate adrenal cortical and thyroid hormone replacement therapy remain of primary importance. *Female:* Palliation of androgen-responsive, advanced, inoperable breast cancer in women between 1 and 5 years postmenopausal or women in whom castration has shown the tumor to be hormone dependent. Prevention of postpartum breast manifestations of pain and engorgement; there is no satisfactory evidence that this drug prevents or suppresses lactation per se. In osteoporosis androgens may be of adjunctive value to adequate considerations of diet, calcium balance, physiotherapy and general health promoting measures. *Males and Females:* In the treatment of protein depletion states which occur in geriatric patients, in debilitation states, in chronic corticoid therapy, resistant fractures; cryptorchidism; creating a positive nitrogen balance, tissue repair and other anabolic effects. Androgenic steroids may produce a response in aplastic anemias, myelofibrosis, myelosclerosis, agnogenic myeloid metaplasia and hypoplastic anemias due to malignancy or myelotoxic drugs. Androgens are not of value in other anemias.

Contraindications Pregnancy (may virilize female fetus), mammary carcinoma in the male, prostatic carcinoma, severe liver disease, severe cardiorenal disease and severe persistent hypercalcemia.

Precautions Employ with caution in young boys to avoid precocious sexual development and premature epiphyseal closure. Androgens tend to promote retention of sodium and water, therefore, watch for edema—particularly in the elderly. Incidence and severity of edema have been minimal and have been associated only with high doses used for palliation of breast cancer. Hypercalcemia may occur, particularly in patients with metastatic breast carcinoma; if this occurs the drug should be discontinued. Changes in liver function tests, such as increased BSP retention and SGOT levels, can occur during therapy. Jaundice has been rarely reported. If liver function tests are altered, discontinue medication or reduce dose. Priapism is indicative of excessive dosage and is indication for temporary withdrawal of drug. When treating protein depletion states or osteoporosis, an adequate diet should be provided and prolonged immobilization avoided whenever possible. When treating aplastic or hypoplastic anemias, androgen therapy should not replace other measure such as transfusion, correction of iron deficiency, antibacterial therapy, and the use of corticosteroids.

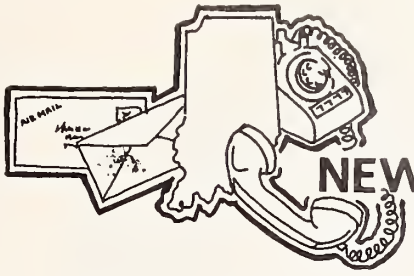
Adverse reactions Nausea, dyspepsia, menstrual irregularities, hepatic dysfunction, priapism, edema, precocious sexual development, and premature epiphyseal closure in young patients have been reported. *Male*—Prolonged administration or excessive dose may cause inhibition of testicular function with oligospermia and decreased ejaculation volume. *Female*—Large doses or prolonged administration may produce masculinization with signs such as hirsutism, deepening of the voice, enlargement of the clitoris, acne, and sometimes, increased libido.

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NEWS NOTES

Six Hoosiers Named to American College of Physicians

Five Indianapolis and one Fort Wayne physician are among the new members of the American College of Physicians. They are: **Drs. Duke H. Baker, William M. Dugan, Jr., Richard L. Need, Victor E. Schlossberg, Jr., and Myron H. Weinberger,** all of Indianapolis, and **Dr. William R. Clark, Jr., Fort Wayne.**

Heart Association and IAGP Present Seminar on Risk Factors

Dr. Donald T. Olson, South Bend, served as moderator for the seminar on coronary risk factors held recently in South Bend. Sponsors were the St. Joseph County Heart Association, the Indiana Academy of General Practice and the Indiana Heart Association. Other participants were **Drs. William C. Elliott and Morton E. Tavel, Indianapolis.**

Dr. Newton on Parenthood Forum

Dr. Roger Newton, medical director for Planned Parenthood of Evansville, participated in a forum on "Methods of Sex Education" at the annual meeting of the Society for the Study of Reproduction at Boston University recently.

Speaks to Hospital Auxiliaries Members

Dr. Jean Pilot, Hammond, was a guest speaker at a recent meeting of the Northwest Area of the Indiana Hospital Auxiliaries Association. "Concepts of the Newer Treatment of Cancer" was Dr. Pilot's topic.

Colorado Physicians Adopt Plan Similar to California's

The Hartford Insurance Group is providing medical malpractice insurance for the Colorado Medical Society. The plan is similar to that introduced by Hartford last year with the Southern California Physician's Council. It provides insurance with limits up to $5 million. A special feature is a reserve fund which will pay premium refunds if paid claims do not use up all the fund. A physicians' peer review committee will assist in evaluating applications for coverage.

Anesthesiologists Elect Dr. Stein

At the annual meeting of the Indiana Society of Anesthesiologists it was announced that **Dr. Richard H. Stein, Vincennes,** had become a member of the board of directors of the American Society of Anesthesiologists.

Dr. Garber to Serve as Parade Marshal

Dr. J. Neill Garber, Indianapolis, will serve as parade marshal for the Dunkirk Glass Days Festival parade on July 28. A native of Dunkirk, Dr. Garber is serving as president of the American Orthopedics Association.

Disclosure of NAS-NRC Drug Efficacy Study Group Evaluations in Drug Labeling and Advertising

A statement by C. Joseph Stetler,
President, Pharmaceutical
Manufacturers Association

We are in full accord with the principle that doctors should have all possible information about the medicines they prescribe, and we recognize that the Food and Drug Administration has a role to play in such an endeavor. However, the mechanism outlined in the regulation published by FDA in the Federal Register of June 8 will poorly serve both medicine and the public. It creates a bog of semantics more apt to mislead and confuse than to inform physicians. It obscures the key question of what the NAS-NRC panels really meant in rating medications as "ineffective," "possibly effective," "probably effective," and "effective but." Many products placed in qualified categories were actually considered by members of the panels to be effective. To publish such imprecise and misleading phraseology as medical dogma is a disservice to the medical profession.

It should again be made clear that judgments rendered by these panels represented limited medical opinion, no matter how expert. Recommendations were often made by split vote and by compromise, which is hardly surprising given the state of the art. The panels used different criteria and methods of operation. In many cases a labeling modification, not the effectiveness of the medication, was in question. Panelists differed on interpretation of "substantial evidence." Sometimes, FDA judgments differed from those of the panels. The confusion that exists is further illustrated by the return of several hundred drugs rated as effective but" by FDA to the Drug Research Board for "clarification." How these cases will be handled by their manufacturers is not clear.

If the terminology used means different things, depending upon the product and the panel, how is the practicing physician to draw meaningful conclusions? And does he expose himself to professional liability suits by prescribing products termed as anything other than "effective"?

Finally, it is premature to place medicines in prescribed categories before final decisions are rendered on their merits. Such a mechanism could be damaging to products whose values in therapy have long been recognized by practicing doctors and which will undoubtedly remain on the market in the future.

Butler University Honors Dr. Donald E. Wood

Dr. Donald E. Wood, Indianapolis, was one of three Hoosiers on whom honorary degrees were conferred at the Butler University commencement last month. He was awarded the doctor of science degree and William D. Ruckelshaus, director of the Federal Environmental Protection Agency, and Wabash College president Dr. Thaddeus Seymour were awarded the doctor of laws degree.

Notre Dame to Be Site of 1972 Football, Basketball Conference

The American Football and Basketball Conference for 1972 will be held at the University of Notre Dame March 23 to 26. Thousands of football and basketball coaches, athletic directors, associates from college, junior college, and high school ranks are expected to attend. Almost 30 leading authorities will speak. Dr. James A. Nicholas, Team Physician and Orthopedic Consultant to the New York Jets and New York Knickerbockers, will head the medical panel. Write the Conference at 845 N. Broad St., Philadelphia 19123.

Dr. Paul Crimm Honored

The late **Dr. Paul D. Crimm, Evansville,** was honored at the annual meeting of the Vanderburgh Tuberculosis and Respiratory Disease Association; the organization's mobile x-ray unit was named for him.

Athletic Injuries Clinic Held at Ball State University

Drs. Leland Brown, Jack Moore and Jack Walker, Muncie, participated in the 1971 Sports Medicine Conference held at Ball State University June 23.

Dr. B. K. Zaring Retires

Dr. B. K. Zaring, a Columbus physician for 36 years, closed his office recently and retired from the practice of medicine. A 1930 graduate of the Indiana University School of Medicine, he opened his office in Columbus in 1935. He served for four years in the Army medical corps and is a past president of the Bartholomew-Brown County Medical Society.

Dr. Stinson Named Hospital Trustee

Dr. William M. Stinson, Anderson, has been appointed a member of the board of trustees of St. John Hospital. He has maintained an office in Anderson since 1956 and is immediate past president of the hospital's medical staff.



THE I.U. School of Medicine has established a Louis B. Russell Scholarship Fund to recruit more black students for the state medical school. The fund was proposed by the school's Committee on Minority Student Affairs as part of a major, comprehensive program of recruitment from minority groups. The scholarship is named in honor of Louis B. Russell, an Indianapolis schoolteacher who is the world's longest surviving recipient of a transplanted heart. The committee members pictured with Mr. Russell above are, from left to right, Carleton C. Greene, Indianapolis; Delmar C. Sanders, Hollandale, Miss.; Bennett B. Desadier, Gary; Mr. Russell; Phillip Skinner, South Bend; Eugene W. McDonald, South Bend.

New Family Practice Diplomates Named

A number of Hoosier physicians have recently been certified as Diplomates of the American Board of Family Practice. Among them are: **Drs. Charles McCalla, Paoli; C. R. Chambers, Union City; Fred Blix, Ladoga; Samuel Millis, Crawfordsville; Robert and Richard LaSalle, Wabash; Philip Myers, Armand Rigaux, John Hildebrand, South Bend; David Spalding, Mishawaka; Julian D. Present, Donald F. Buchner and Robert F. Walter, Evansville.**

Dr. Herman Baker Named Life Member, Dr. Owen Slaughter Named Trustee

Dr. Herman Baker, Evansville, has been named to a non-voting life membership on the board of trustees of the University of Evansville, while **Dr. Owen L. Slaughter, Evansville,** has been appointed to membership on the UE board of trustees.

Dr. Porter Honored on 90th Anniversary

Dr. E. A. Porter, Westport, was guest of honor at a family gathering recently in observance of his 90th birthday anniversary. Dr. Porter still goes to his office every day and evening and also still makes "a few" house calls on persons he has treated throughout his long career. He was a member of the first class of physicians to graduate from the Indiana University School of Medicine in June 1908 and has practiced at Westport since 1931, serving previously as a physician at Burney for 10 years and at Hartsville for 13 years. The birthday celebration was held at the home of his son, **Dr. Robert A. Porter,** near Westport, and Hester, his wife of 60 years, all eight of their children and nearly all of their many grandchildren planned to be present.

State Nurses Association Hears Dr. Thomas Krueger

"Pathophysiology of the Spinal Cord Injury" was the subject of the talk given by **Dr. Thomas Krueger, Evansville,** at a recent meeting and workshop sponsored by District 4 of the Indiana State Nurses' Association.

Dr. Kenneth Miller On Panel

Dr. Kenneth Miller, Woodburn, was one of a panel of experts on the problem of abortion at a recent Sunday evening program at the Grabill Evangelical Mennonite Church. He spoke on the medical aspects of the problem; others gave theological, legal and social viewpoints.

Dr. Rosenbaum Speaks at Awards Banquet

Dr. Lloyd E. Rosenbaum, Anderson, chief of staff of St. John's Hickey Memorial Hospital, was a speaker at the hospital's annual service awards banquet recently.

Dr. T. O. Middleton Honored

This year's winner of the Bloomington Exchange Clubs' "Book of Golden Deeds" award for 1971 is **Dr. Thomas O. Middleton, Bloomington** pediatrician.

Auerbach Award to Dr. Warren Tucker

Dr. Warren S. Tucker, Indianapolis, was the recipient of the 1970 Auerbach Award, presented annually to an outstanding individual who has been active in the prevention, control and treatment of tuberculosis. Presentation was made at the annual meeting of the Tuberculosis and Respiratory Disease Association at Indianapolis recently.

Continued

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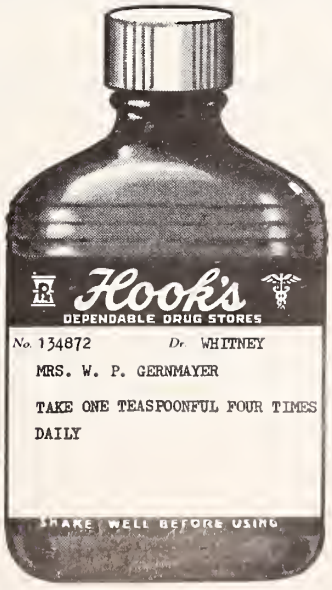
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NEWS NOTES

Continued

Eaton Laboratories to Change Drug Identification Code

Eaton Laboratories was among the first in the pharmaceutical industry to adopt an identification code system some three and one-half years ago, and since then has worked with others to formulate the National Drug Code which will be used by all manufacturers. The NDC system consists of a three-part compound number to identify the maker, the product and strength, and the package size. For example, Dopar® (levodopa, Eaton) capsules, 250 mg, bottle of 100, will be identified by NDC 35-0014-01. Eaton will continue to impress the word "Sample" on all tablets and capsules to indicate products that are intended for professional samples and may not be sold.

Blue Shield Honors Dr. Crowder

Dr. J. Harve Crowder, Sullivan, was one of those honored at the ceremonies marking the 25th anniversary of the founding of Blue Shield of Indiana recently. Dr. Crowder was one of the founders and members of the first board of directors.

Dr. J. O. Ritchey Elected Master By American College of Physicians



Dr. J. O. Ritchey, Indianapolis, professor emeritus of medicine and long time chairman of the admissions committee for the I.U. School of Medicine, was honored recently when he was elected a master of the American College of Physicians.

Only physician in Indiana ever so honored, Dr. Ritchey already was a governor of the ACP. There are 83 masters in the college.

Dr. David Trout Named

Dr. David J. Trout, Lafayette, has been named to that city's health board. His term runs until Dec. 31, 1974.

Doctors Honored at Loogootee

Drs. E. B. Lett and Robert Chattin, Loogootee, were among those honored by American Legion Post 120 recently. The occasion was the 52nd anniversary of the founding of the Post. Special recognition certificates were presented.

Dr. Haley to Aid in Fund Drive

Dr. George M. Haley, South Bend, will be a division chairman for the 1971 United Way campaign. He is a director and past-president of the United Way and will head the division which includes physicians, attorneys, dentists and osteopaths. He spoke highly of these professional groups. "The physicians, for example, last year gave the second highest total dollars of all the counties our size in the nation," Dr. Haley said.

Governor Names Dr. Owen Slaughter

Dr. Owen L. Slaughter, Evansville, has been appointed to the Indiana State Board of Health and has also been named to the board's seven-member executive committee. He is a member of the Evansville Air Pollution Control Board and the health planning council for that area.

Two Become Radiology Fellows

Drs. Richard M. Craig and David C. Gastineau, Fort Wayne, were named Fellows of the American College of Radiology at the 48th annual meeting of the ACR in St. Louis recently.

Elected to Pediatric Academy

Dr. Robert S. Kepner, Anderson, was one of 408 pediatricians elected to Fellowship in the American Academy of Pediatrics at its recent session in St. Louis. ◄

About Our Cover

In the early 1880s William Davies Hutchings, M.D., purchased a home at 120 West Third Street, Madison, where he lived with his wife and eight of their nine children.

Adjacent to the house was a two-storied building which was used as an office and hospital or, as an article in the *Madison Star* said: "a pharmaceutical dispensary for the alleviation of bodily infirmities."

Doctor Hutchings practiced here until his death in 1903 and the building and its furnishings and equipment have been donated to Historic Madison, Inc., as a memorial to the physician by his granddaughter, Elisabeth Zulauf Kelemen, author of "A Horse-and-Buggy Doctor in Hoosierland," and her husband, Pal Kelemen, a noted archaeologist, of Norfolk, Conn.

Restoration of the building and of the doctor's office with the original equipment used by Doctor Hutchings was undertaken by Historic Madison, Inc., which provides hostesses for the building. The Jefferson-Switzerland County Medical Society donated $6,361.59 which is in trust with the interest going towards the upkeep of the building. The Riverview Garden Club of Madison is providing a medicinal herb garden in the back yard as an added attraction.

The Journal is indebted to Dr. Merritt Alcorn of Madison for arranging for the preparation of Mrs. Kelemen's article and furnishing editorial assistance.

Thank You, Doctor



Your continuing cooperation with the American Association of Medical Assistants has been generous. With your support our organization has achieved a membership of 14,000 medical assistants in more than 400 chapters in 45 states, District of Columbia and Puerto Rico.

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- Carried on a continuing education program for medical assistants through seminars, workshops and a professional bi-monthly journal.
- Published career materials and established a scholarship loan fund to help recruit future medical assistants.
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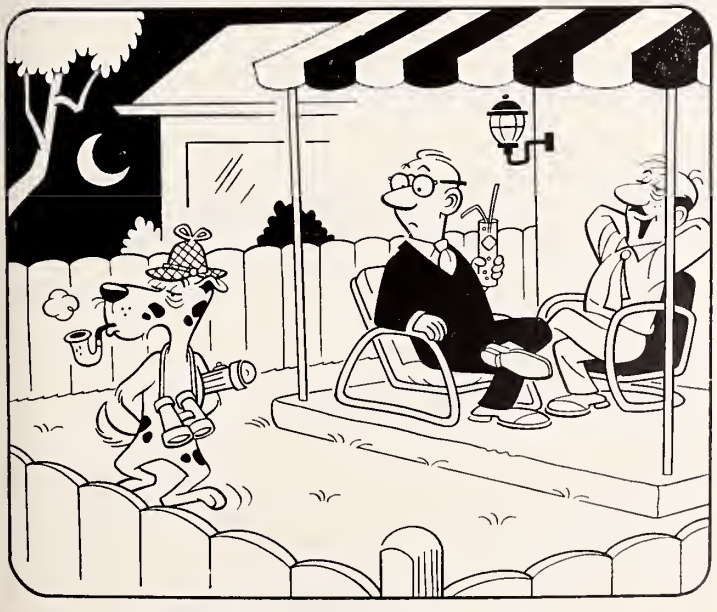
FRANKLIN 25th YEAR

From *The Journal* 50 Years Ago

It seems advisable to digress at this juncture from the primary subject matter to a brief consideration of the pathological manifestations of arterio-sclerosis. The disease is made manifest by impaired nutrition and elimination, a dry, hard and non-elastic skin, and certain mental symptoms, all of which are in proportion to the state of the disease. There is more or less dyspnoea on exercise and this is also produced by lowering of the barometer, the more so when there is involvement of the coronary artery and aorta. The direct tissue changes are marked thickening of arterial walls, and later a calcareous degeneration with corresponding loss of elasticity. The advanced state of the disease is readily demonstrable by roentgenography. Adami objects to the name of this disease, urging that it is neither adequate nor comprehensive.

The cause of arterio-sclerosis remains the subject of dispute, theory and conjecture. Syphilis and alcohol have thus been indicted for the crime of arterio-sclerosis. This seems consistent, for they have been charged with causation of practically every other more or less obscure disease, so why not with arterio-sclerosis.

In my personal observations, which, needless to say, cover many cases other than the few I shall report herein, I have found no evidence that either syphilis or alcohol are productive of this malady, and Cabot, after extensive clinical data, acquits alcoholism as a causative factor. Adami believed that overeating is productive of the disease. I make bold to suggest that auto-intoxication resulting from over-eating and constipation is the cause of the majority of cases. . . . James N. McCoy, M.D., Vincennes, "The Systemic Reaction of the Roentgen Ray," *JISMA*, July 1921.



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FUTURE MEETINGS, SEMINARS, COURSES

Advanced Emergency Care Course Set

An advanced practical course, "Emergency Care and Transportation of the Sick and Injured," sponsored by the American Academy of Orthopaedic Surgeons' Committee on Injuries in conjunction with the University Medical Center, will be conducted at Madison, Wis., Aug. 25-28. Write: Emergency Care Conf., The Wisconsin Center, 702 Langdon St., Madison 53706.

Occupational Health Congress to Meet

The AMA Congress on Occupational Health will be held at Jackson Lake Lodge in Grand Teton National Park, Wyoming, on August 29 and 30.

Symposium on Polytomography Of Temporal Bone Announced

The fourth two-day Symposium on Polytomography of the Temporal Bone will be given under the auspices of The Wright Institute of Otology at Community Hospital, Indianapolis on October 9 and 10, 1971.

Subjects covered are: "Basic Anatomy of the Temporal Bone" and "Technique of Polytomography of the Temporal Bone" with demonstrations of normal tomograms. Pathological conditions revealed by polytomography, such as cholesteatoma, ossicular chain problems, otosclerosis, fractures, foreign bodies, tumors, and congenital anomalies are shown on original tomograms and the clinical applications discussed.

Number of registrants is limited to 18. Fee for the course is $150.00.

Inquiries should be directed to: The Wright Institute of Otology, Inc., Community Hospital of Indianapolis, Inc., 1500 North Ritter Avenue, Indianapolis, Ind. 46219.

Cancer Conference Scheduled

The Seventh National Cancer Conference will be held at the Biltmore Hotel, Los Angeles, September 27 to 29, 1972. The Conference is sponsored by the American Cancer Society and the National Cancer Institute. It meets every four years to provide a meeting place for cancer researchers and clinicians to review progress in treatment. All physicians are invited.

Postgrad Course in Laryngology, Bronchoesophagology, Oct 4-9

The Department of Otolaryngology of the University of Illinois at the Medical Center will conduct a postgraduate course in Laryngology and Bronchoesophagology from October 4 through 9, 1971. This course is limited to fifteen physicians and will be under the direction of Paul H. Holinger, M.D. It will be held largely at the University of Illinois Hospital Eye and Ear Infirmary, 1855 West Taylor Street, Chicago, and will include visits to a number of other Chicago hospitals. Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures and several motion pictures.

Interested registrants will please write directly to the Department of Otolaryngology, Abraham Linclon School of Medicine, University of Illinois at the Medical Center, P.O. Box 6998, Chicago, Ill. 60680.

U of Miami Sets Postgraduate Course In Otolaryngology for Family Physician

On October 8 and 9, 1971, The Department of Otolaryngology, University of Miami School of Medicine, will present "A Postgraduate Course in Otolarnygology for the Family Physician." To be held at the Sheraton Four Ambassadors Hotel, Miami, the course carries 9 hours AAGP credit.

For details write: F. W. Pullen, II, M.D., Neuro-Otologic Laboratory, School of Medicine, P.O. Box 875, Biscayne Annex, Miami, Fla. 33152.

University of Illinois to Host Annual Otolaryngologic Assembly

The annual Otolaryngologic Assembly of 1971 will be held October 23 through 29, 1971, in the University of Illinois Hospital Eye and Ear Infirmary. The Department of Otolaryngology, Abraham Lincoln School of Medicine, University of Illinois at the Medical Center, offers a condensed postgraduate basic and clinical program for practicing otolaryngologists under the direction of Emanuel M. Skolnik, M.D. It is designed to bring to specialists current information in medical and surgical otorhinolaryngology.

Interested otolaryngologists should direct their inquiries to the mailing address: Otolaryngology, P.O. Box 6998, Chicago, Ill. 60680.

AGA Schedules Three Regional Postgraduate Courses

The American Gastroenterological Association will conduct regional postgraduate courses on October 23, 1971. Simultaneous sessions will be in Pittsburgh, San Antonio and Portland, Oregon. The tuition fee is $50 ($15 for those in training status), which includes the lunch. The course is approved for 6 hours prescribed credit by the AAGP. Write Mrs. Frances T. Chalmers, Box 190, McLean, Va., 22101.

Symposium on Hematological Problems in the Newborn Set

The Department of Pediatrics, University of Louisville School of Medicine, will present its Fifth Annual Newborn Symposium, November 4-5, 1971 on Hematological Problems in the Newborn. Participants (alphabetically) will be: Drs. Richard Behrman, John M. Bowman, Louis K. Diamond, Bill Hathaway, Alvin Mauer, Frank Oski, and faculty of the Department of Pediatrics, University of Louisville School of Medicine. For further information write: Billy F. Andrews, M.D., Professor and Chairman, Department of Pediatrics, 226 East Chestnut Street, Louisville, 40202. ◄

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Deaths

William O. Beebee, M.D.

Dr. William O. Beebe, coroner of Parke County, died in an auto accident June 14.

Dr. Beebe, who was 57, was a graduate of Rush Medical College. He came to Parke County in 1962 and had served as coroner for eight years.

A member of the Parke-Vermillion County Medical Society, he was a veteran of World War II, serving with the U. S. Navy.

Walter Donald Close, M.D.

Dr. Walter D. Close, 63, assistant director of hospitals at the Indiana University Medical Center, Indianapolis, died at his home May 14.

A fellow of the American College of Physicians, a diplomate of the American Board of Internal Medicine, and a fellow of the American College of Chest Physicians, he was a former member of the Marion County Medical Society.

He had been in private practice in Indianapolis from 1939 to 1957 except for four years during World War II when he served in the Army Medical Corps in Iceland and in California.

He graduated from the I.U. Medical School in 1933 and did part-time teaching there from 1939 to 1957 when he became director of the postgraduate medical education department.

George D. Colip, M.D.

Dr. George D. Colip, team physician and medical director at the University of Notre Dame, died May 4 in St. Joseph's Hospital, South Bend, after an extended illness. He was 59.

A graduate of the Loyola School of Medicine, Dr. Colip did graduate work at the University of Pennsylvania.

During World War II he commanded a mobile field hospital, landing on Omaha Beach. He was involved in the five major campaigns of the European theater.

Dr. Colip was a member of the St. Joseph County Medical Society.

Lawrence M. Gholz, M.D.

Dr. Lawrence M. Gholz, assistant medical director for the Delco-Remy Division at Anderson since 1966, died June 17 at Community Hospital, Anderson.

Since 1968, Dr. Gholz had served as Madison County coroner. He was a graduate of the University of Southern California and saw four years' service in World War II as commanding officer of an Air Force Reserve unit in Michigan.

Dr. Gholz was a member of the Madison County Medical Society and was a fellow of the American College of Preventive Medicine.

Edmund B. Haggard, M.D.

Dr. Edmund B. Haggard, 72, died May 11 in his home in Indianapolis. A 1923 graduate of the Indiana University School of Medicine, he was a member of the National Industrial Physicians Association and was a Senior member of the ISMA.

He served in the Army during the Mexican border expedition and World War I. During World War II he was with the Army Air Corps and served in China, Burma and India.

Raymond Mitchell, M.D.

Dr. Raymond E. Mitchell, 77, former Indianapolis physician, died May 8 in Springfield, Mo., where he had made his home since his retirement in 1965. He had served as a commissioned medical officer at the U. S. Marines Hospital at Fort Stanton, N.M., and at the U.S. Medical Center at Springfield.

He was a graduate of the University of Illinois School of Medicine and served on the faculty of the Indiana University School of Medicine and was in private practice in Indianapolis from 1921 to 1948.

A past president of the Indiana University Alumni Association, he was a former member of the Marion County Medical Society.

Ernest Omar Nay, M.D.

Dr. Ernest Omar Nay, retired Terre Haute urologist, died May 10 at Union Hospital. Seventy-eight years of age, he served as chief of urological service at Union Hospital from 1925 to 1952.

In 1919 he graduated from the Harvard Medical School, and in 1927 did postgraduate study in Vienna.

Professional memberships included the American Urological Society and the Vigo County Medical Society.

William C. Reed, M.D.

Dr. William C. Reed, 76, former Bloomington resident, died April 11 in Naples, Fla.

A native of Bloomington, Dr. Reed was in general practice in Bloomington from 1920 until he retired in 1962.

Dr. Reed was a member of the Owen-Monroe County Medical Society, and a Senior Member of the Indiana State Medical Association.

Gerald T. Watterson, M.D.

Dr. Gerald T. Watterson, Connersville, died May 15 at Fayette Memorial Hospital. He was 64.

A former Fayette County health officer and deputy coroner, he maintained an office in Connersville for nearly 40 years.

He was a graduate of the Indiana University School of Medicine and a member of the Fayette-Franklin County Medical Society.

County, District News

First District

Dr. George Willison was honored at the meeting of the First District Medical Society on May 6. He had served for 12 years as Blue Shield representative from the First District and was retiring, to be succeeded by Dr. Willard Barnhart.

Dr. Ray Burnikel was elected District president; Dr. Bernard B. Rosenblatt, vice president, and Dr. William Dye, secretary-treasurer. Dr. Gilbert Wilhelmus was elected trustee.

Second District

Dr. J. S. Brown, Carlisle, was elected secretary of the Second District for his 50th consecutive term at the May 27 meeting at Washington. Dr. Joe Dukes was re-elected Blue Shield director and Dr. Betty Dukes was re-elected alternate trustee.

Third District

New officers were elected at the April meeting of the Third District Medical Society at New Albany. Dr. Daniel H. Cannon, New Albany, continues as president, while Dr. Charles X. McCalla, Paoli, is the new secretary. Others named were: Dr. John M. Paris, New Albany, Blue Shield board member, and Dr. Thomas A. Neathamer, Jeffersonville, alternate trustee.

Fourth District

The Fourth District met at Aurora on May 19 and the following officers were elected: President, Robert O. Zink, Madison; vice president, William J. Ryan, Columbus; secretary, Ott B. McAtee, Madison; trustee, Jack E. Shields, Brownstown; alternate trustee, Howard C. Jackson, Madison.

The 1972 meeting will be held May 17 at Madison.

Fifth District

Dr. Burton E. Scherb, Terre Haute, is the new president of the Fifth District Medical Society; Dr. James W. Cristee, also of Terre Haute, was re-elected secretary. The 1972 meeting will be held at Terre Haute on May 24.

Sixth District

The Sixth District's new president is John Moenning, Greenfield, and Dr. James H. Tower, Jr., Shelbyville, is the new secretary. The 1972 meeting will be held on May 3 at Shelbyville.

Eighth District

At the annual meeting of the Eighth District Medical Society at Portland on May 26, Dr. Franklin K. Beeler, Anderson, was elected president. Dr. Edward R. Bush, M.D., Anderson, will serve as secretary-treasurer. June 7 was set as the date for the 1972 meeting.

Ninth District

The Ninth District Medical Society met at the Lafayette Country Club on June 3, and Dr. Max Hoffman was elected alternate trustee.

Tenth District

Dr. Vincent Santare was re-elected Trustee when the members of the Tenth District met at the Lake Hills Country Club on June 2.

Dr. Lee Trachtenberg, president of the Calumet Foundation for Medical Care, described the purposes and operation of the Foundation.

Twelfth District

Three officers were re-elected at the May 19 meeting of the Twelfth District, as follows: President, Dr. George Manning, Ft. Wayne; vice president, Dr. Frank Bryan, Ft. Wayne; secretary-treasurer, Dr. Brad Hughes, Waterloo.

Dr. Walter Griest, Ft. Wayne, will serve as the new alternate trustee.

Dr. Raymond Robillard, president of the Federation of Medical Specialists of the Province of Quebec, was the speaker of the evening.

Allen

Dr. Kenneth F. Isenogle will serve as secretary of the Allen County Medical Society for the coming year, with Dr. Richard B. Juergens serving as secretary. Both are of Fort Wayne.

Boone

Dr. McFadden, Lafayette pathologist, presented a program on "Cholesterol and Triglycerides and the Treatment of Coronaries" at the May 4 meeting of the Boone County Society.

Officers elected were: President, Dr. Kathryn Jackson, Zionsville; vice president, Dr. Jack Lenox, Lebanon; and secretary, Dr. Gerald Fisher, Lebanon. Dr. Don Boyer, also of Lebanon, was elected delegate. They will hold office until June 1973.

Carroll

The Carroll County Medical Society held its annual dinner for members' employees and their spouses April 21 at the Suburban Inn at Flora. As usual, there was 100% attendance.

"Medicine in Rhodesia" was the subject of the talk by Dr. Robert Walker, who described, with the aid of slides, the practice of medicine in that part of Africa.

Clinton

Dr. Milton Erdel, Frankfort, spoke to the Clinton County Society April 27 on Senate Bill 164. Eight members were present.

Dearborn-Ohio

Thirteen members and ten guests attended the April meeting of the Dearborn-Ohio County Medical Society. Dr. Stephen Hogg, president of the Cincinnati Academy of Medicine, spoke on Foundations for Medical Care.

Dr. Gerald T. Bowen, Lawrenceburg, was elected president of the Dearborn-Ohio Society on June 3. Dr. G. S. Fessler, Rising Sun, will serve as vice president; and Dr. Leslie M. Baker, Aurora, was re-elected secretary-treasurer.

Fountain-Warren

ISMA president-elect Dr. Peter R. Petrich, Attica, reported on activities of the state association at the April 15 meeting of the Fountain-Warren County Medical Society.

Officers elected that night were: President, Dr. V. F. Raymundo, Attica; vice president, Dr. T. T. Suzuki, Covington; secretary-treasurer, Dr. T. C. Person, Veedersburg. Dr. M. N. Hoffman, Covington, was named Fountain County delegate to the ISMA, with Dr. Lowell Stephens, also of Covington, alternate. Warren County's delegate will be Dr. William Ringer, Williamsport, while Dr. Carl Nelson, West Lebanon, will serve as alternate.

Grant

Fifty members were present for the May 25 meeting of the Grant County Medical Society at Emley's Restaurant. Dr. E. E. Smith reported that six medical students from the Medical School's M.E.C.O. Program would be working at the county hospitals and it was voted that these students be invited to be guests of the society at future meetings.

At the society's May meeting, Dr. William J. Bean, a dermatologist with the Mayo Clinic, discussed "Cutaneous Clues to Internal Malignant Disease."

Hancock

Eleven physicians and two dentists, together with wives of most of them, attended the April meeting of the Hancock County Medical Society at the hospital in Greenfield.

Dr. Ralph Rea, society president, discussed the nurse's scholarship program that was established by the society a number of years ago. It was voted to put $1,000 in the fund each year.

Huntington

Dr. Robert Harger, Indianapolis, spoke on "Problems in Ophthalmology" at the May meeting of the Huntington County society.

New officers were elected, as follows: President, Dr. D. Richard Gill; vice president, Dr. H. S. Brubaker; secretary-treasurer, Barth E. Wheeler, all of Huntington.

Jay

The new officers of the Jay County Medical Society are: President, Dr. Alfonso E. Lopez; and secretary, Dr. Joseph F. Vormohr, both of Portland.

Johnson

Dr. Mac Roller has been elected president of the Johnson County Medical Society, and James Nalley, secretary. Both are of Franklin.

LaPorte

Dr. James W. Strickland, Indianapolis, discussed care of the injured hand for members of the LaPorte County Medical Society at their May meeting. "Coronary Arteriography" was the title of the presentation by Dr. Joseph Muenster, Chicago, at the group's April meeting.

Marshall

Dr. James Farner, South Bend gastroneurologist, presented a program on "The Irritable Bowel Syndrome" at the April meeting of the Marshall County Medical Society.

Officers elected were: President, Dr. James Hampton, Argos; vice president, Dr. Michael Deery, Culver; and secretary, Dr. Jose DeJesus, Jr., Plymouth.

Miami

Dr. Lewis C. Robbins, Indianapolis, discussed health hazard appraisals for members of the Miami County Medical Society at their May meeting held at Peru's Mississinewa Country Club.

Montgomery

Thirteen members were present at the April meeting of the Montgomery County Medical Society. Mr. John Porter of the USV Pharmaceutical Corporation presented a film on diabetes.

Dr. Carl B. Howland, Crawfordsville was elected president of the Montgomery County Medical Society at its June meeting.

Parke-Vermillion

Dr. F. J. Swaim, Rockville, was elected president of the group when it met on April 19. Dr. A. M. Montecillo, Clinton, was chosen secretary.

Rush

Dr. Willard Worth, president of the Rush County Medical Society, showed slides and read the commentary on electrocardiograms put out by the Krannert Institute at the June meeting of the society.

Tippecanoe

"What it Takes to Have an Acceptable Mental Health Center" was the subject of the talk given by Dr. John Bowman, director of the Howard County Mental Health Center, at the May meeting of the Tippecanoe County Medical Society.

Dr. Chester L. Waits, Lafayette, spoke on "What They Won't Tell You in Medical School" at the April 27 meeting. Medical students, pre-medical students and their wives were guests, as were wives of members.

Vanderburgh

Dr. Ray Burnikel is the new president of the Vanderburgh County Medical Society, and Dr. William Getty was named president-elect. Other officers chosen at the May 11 meeting were: vice president, Dr. L. Ray Stewart; treasurer, Dr. Jerry Becker; ISMA delegates, Dr. John D. Wilson and Dr. George Willison; and alternate delegates, Dr. Forest Radcliff and Dr. Weston Heinrich. Drs. William Grimm and Ray Newnum were named to the board of directors and Dr. John Alexander was named to the board of censors.

Wayne-Union

The new president of the Wayne-Union County Medical Society is Dr. George Johnson. Other officers who will serve for the coming year are: President-elect, Dr. Tom Ebbinghouse; secretary, Dr. John R. Dehner; treasurer, Clarence G. Clarkson; delegates, Dr. Glen Ward Lee and Dr. Tom S. Shields; and alternate delegates, Drs. John D. Stepleton and James R. Daggy, all of Richmond.

Wells

Twenty-one physicians and their wives attended the program on Human Sexuality given by Drs. Edward Tyler and John Wilms.

Dr. Russell Graf is the new secretary-treasurer of the society.

White

New officers of the White County Medical Society are: Dr. Kingdon Brady, West Lafayette, president, and Dr. W. Martin Dickerson, Monticello, secretary. ◄

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Association News

BOARD OF TRUSTEES

March 28, 1971

The Board of Trustees of the Indiana State Medical Association convened at 9:00 a.m. in the Association Headquarters building on Sunday, March 28, 1971 with Dr. Joe Dukes, chairman, presiding.

Roll call showed the following:

District	Trustee	
1	Gilbert Wilhelmus	Present
2	Joe Dukes	Present
3	Eli Goodman	Present
4	Robert Reid	Absent
5	Wilbert McIntosh	Absent
6	Stephen Smith	Present
7	Dwight Schuster	Present
7	James Gosman	Present
8	Richard Ingram	Present
9	William Sholty	Absent
10	Vincent Santare	Present
11	Lowell Hillis	Absent
12	William Clark	Present
13	Otis R. Bowen	Absent

Distriet	Alternate Trustee	
1	Raymond N. Newnum	Absent
2	Betty Dukes	Absent
3	Elmer Wallace	Absent
4	Jack Shields	Absent
5	Cleon Schauwecker	Present
6	Paul M. Inlow	Absent
7	Joseph Kerlin	Absent
7	John O. Butler	Present
8	Robert Williams	Present
9	Lindley Wagner	Absent
10	Thomas Tyrrell	Present
11	James Harshman	Present
12	Frederic Schoen	Absent
13	G. Beach Gattman	Present

Officers:

Malcolm O. Scamahorn, President	Present
Peter R. Petrich, President-elect	Absent
Lester H. Hoyt, Treasurer	Present
Hugh Thatcher, Assistant-Treasurer	Present
Frank B. Ramsey, Editor, *The Journal*	Present

Executive Committee

Donald M. Kerr	Present
Wilbert McIntosh	Absent

Delegates and Alternate Delegates to AMA:

Don E. Wood	Absent
Eugene Senseny	Absent
Frank Green	Absent
John S. Farquhar	Absent
Jack Shields	Absent
James Harshman	Present
Eugene S. Rifner	Present
Kenneth O. Neumann	Present
Patrick J. V. Corcoran	Absent
Thomas Tyrrell	Present

Guests:

Andrew Offutt	Absent
J. M. Black	Absent
Glenn W. Irwin, Jr.	Absent
Sprague H. Gardiner	Absent

Staff:

Robert J. Amick	Present
John L. Walters	Present
James A. Waggener	Present
Howard Grindstaff	Present
Kenneth W. Bush	Present

Minutes of Meeting Held January 31

Approved on motion of Dr. Scamahorn with Dr. Clark asking that the record for the January 31 meeting show that he was not in favor of the provisions for licensing of foreign physicians.

DR. SCAMAHORN: I have been giving you reports of the meetings I have attended. Dr. Petrich has two reports at this time which I think are very good—one on the Ad Hoc Committee on Medical Assistants. I believe that before the next session of the legislature we should bring in some of the other allied groups for discussion on physician's assistants as they are the ones that caused us some difficulty in this current session.

I want to thank Dr. Gosman for appearing on the "Suds Bill," as it is called. He did a marvelous job in handling the attorneys for the industry in discussing all the provisions of this bill.

You members of the Board ought to plan to attend sometime during a session of the state legislature and see how it works. I have learned a lot and I am sure that your visual experience would give you a much better insight into the workings of the General Assembly.

I have attended, since the last meeting, 22 meetings, either representing you or meetings in which I felt we should be represented. I have spent five full days in Washington and you will be glad to know that the Indiana Auxiliary received an award from the AMA AMPAC Program. Our Congressional visit, I thought, was very effective. Birch Bayh did not show; however, his staff was there. Vance Hartke dropped in, John Brademas was not present, and Andy Jacobs did not attend. All others, however, were there and I will say that Dr. Haley, along with Dr. Petrich and Mrs. Gattman, had lunch with Brademas and we feel we had a very favorable warm-up to this man. My impression is that the Congressmen are definitely concerned about the Health Care Program. They are not with Kennedy on his proposal and I mean to say they tell you this is not the approach. We have commented this is not the answer—but what do the doctors want and what are your thoughts? They definitely want to hear from us.

You might be interested to know that Brademas, who is the assistant whip in the House of Representatives, has requested a meeting with the doctors up there in his district. He wants to hear our side of the story and has said, "I will listen to you."

The Malpractice Symposium held for the Chiefs of Staff of hospitals, Hospital Administrators, Boards of Trustees and physicians was very successful, in my opinion. I would also like to thank Bill Clark, Lowell Hillis, Jim Harshman, Dwight Schuster and Les Hoyt for taking time to attend this meeting. Mr. Smithers, the former deputy insurance commissioner from the State of Pennsylvania, pointed out that malpractice is one problem that can not be solved by any one of the disciplines —whether it be legal, medical or insurance. He pointed out the biggest cost is the cost of defense. If you think your rates have gone up, I believe he said the average cost for a car in Philadelphia with a teenage driver was $1800. He made some general statements, one pointing out that the rise of rates is inevitable because of the rise in the cost of defense and that claims in the future are going up. He pointed out that we were wrong in insisting, as many hospitals do, that hospital records are confidential and should only be released if they are subpoened. He stated we were asking for trouble. He further commented that you should get to know the lawyers better and get to know the judges. Two of his suggestions were: some kind of quality control and a medical-legal Council or so-called arbitration. Dr. Wasmuth from Cleveland did say that, in his opinion, the concept of arbitration was a good idea as was the concept of quality control. Surprisingly, he said the average juror looked favorably on the doctor despite what we think. He said it is borne out time and time again that the average man on the street who is a juror looks favorably upon doctors.

Dr. Robillard, president of the Federation of Medical Specialties of Quebec, related their experience in dealing with their insurance program. I think one of the things we must remember is that after their strike in Quebec, following institution of the compulsory health insurance program, they made themselves into a labor

union under the title of "Federation of Physicians." His explanation of their negotiations was very interesting and, of course, he made some prophecies which were also interesting. One: when the government takes you over, you must unionize to negotiate. There is no alternative. He said, "Remember, and this has been told to you several times, when the administration changes fewer than 125 people change with the administration. The bulk of HEW and social planners stay year after year and these are the fellows you have to argue with and you have to show them some force."

Another interesting comment—when you have peer review—or you have your own group, do not hire full-time doctors to be the quality control. It doesn't work. The minute he goes full time he becomes an employee of the government and he becomes authoritative in your own organization. The big secret, they think in Quebec, is that they pay the doctor for his day off, or the doctor who is doing limited practice. They pay him a reasonable fee to go through and check quality control and guarantee that the patient is getting service. Of course, they have to guarantee under the contract they offer but they were successful in getting a contract on a fee-for-service basis, 90% of what they requested, which was 10 - 15% higher than that proposed by the government. He stated, "You know you are the only ones to render this service, so just tell them it is going to cost 'X' number of dollars and stick with it."

The last speaker was Mr. Hassard, legal counsel for the California Medical Association and the National Association of Blue Shield Plans. He discussed the arbitration program being tried in San Diego County, pointing out that a patient can option whether he wants arbitration or not and in 20 months there have been less than one-half of 1% that have optioned out of this program. They have 30 days following discharge from the hospital to change their mind and they have only had one person option out during this period. In the 20 months the program has been in operation they have not been asked to arbitrate a single case. He pointed out there is a difference between mediation and arbitration. Mediation is non-binding, where you just sit down and talk about it. Arbitration must be binding on all parties who will agree to whatever decision the arbitration committee reaches and that is final. He pointed out that during a 20-month period a total of 146,000 patients had agreed to arbitration and only five had changed their minds. He made a comment which I think bears repeating. "Forget about trying to rule out contingency fees—this is just a lost cause. Legislators won't buy this because it just does not work."

One point I forgot to make in Mr. Smithers comments—where he was talking about the big item being the cost of malpractice—in some areas the hospitals and doctors have gone together and selected the same carrier, which does reduce the cost of defense, and 97% of all cases involve some hospital care. So, by combining, they cut the defense cost in half. Some hospitals have gone so far as to demand that a physician serving on their staff certify that his professional liability insurance is covered by the same carrier that covers the hospital. This has been upheld in the courts that the hospital can demand that you certify that you have a policy in force with their carrier.

CHAIRMAN: The president-elect is vacationing and we will now have the report of the treasurer.

TREASURER: All of you have a copy of the financial statement in front of you and we will leaf through it rather quickly unless you have questions.

The treasurer then reviewed the schedule of receipts and expenditures for the first five months of the current fiscal year; the investment account; the headquarters office expenses; the Journal expenses; the report of the expenses of the committees and commissions; the officers, and the Board.

MOTION

Unless there is some question, I would move that the report be adopted. The motion was seconded by Dr. Santare, put to vote and carried.

The treasurer and the secretary requested that in the future the financial statements be mailed to the members of the Board in advance in time for study before the meeting.

CHAIRMAN: We will now hear from Dr. Ramsey for *The Journal.*

DR. RAMSEY: The advertising business was a little better this year than last and we are attempting to revive the sales effort for local advertising as the gentleman who used to sell for us passed away and we need a new local representative. As near as I can tell, *The Journal* is currently about $3,000 in the red.

CHAIRMAN: We will now go to item #6, report of the Board of Trustees.

MOTION

DR. GATTMAN moved that two physicians of his district be certified for the remission of dues, due to the fact they are quite ill and it is questionable whether they will ever practice medicine again and that the payment of dues would work a hardship on them.

The motion was seconded by Dr. Scamahorn, put to vote and carried.

DR. GATTMAN: We do not have a date for our 13th District meeting.

DR. WILHELMUS—The 1st District meeting will be held in Evansville on May 6.

2nd District—Reported their meeting would be held in Washington, May 27.

3rd District—Their meeting will be held on April 7 in New Albany.

4th District—Their meeting will be held in Aurora May 19.

5th District—No date has been set.

6th District—Greenfield on May 5 and John Pont will be the speaker.

7th District—Martinsville, June 2.

8th District—Portland, May 26.

9th District—Lafayette, June 10 (Note: since has been changed to June 3)

10th District—Sherwood Country Club, June 2, Schererville.

11th District—September 15. Miami County will be the host and the meeting will be held in Peru.

12th District—Ft. Wayne, May 19.

DR. CLARK: I would like to add, we are going to have Dr. Robillard, whom Dr. Scamahorn spoke about a few minutes ago, as our principal speaker. I think every physician in the U.S. should hear what this fellow has to say. We certainly invite you all up to hear this talk.

CHAIRMAN: According to the Bylaws, if a district does not set its meeting, we are expected to set it for them, so will the 5th and 13th try to get meeting dates established so the Board will not have to do this.

We will now move on to item 7, Matters Referred by the Executive Committee.

DR. KERR: The Executive Committee met last night and discussed the usual matters which are currently brought before the committee. I would like to report that the Association of Medical Exhibitors made a survey of the exhibitors at the South Bend meeting and, of the pharmaceutical firms exhibiting, 12 said they would exhibit in '71; two said no and three were undecided. Among publishers, there was one no; of the surgical supply and equipment group, four said yes and one was undecided. Educators and others, seven said yes; one no and two undecided. In registration data, which we thought was interesting, 584 physicians were registered and 202 exhibitors.

I would also like to review for you a report from the AMA Educational Research Foundation. For the year 1969 Indiana physicians contributed $25,685 and the Auxiliary contributed $19,722. In 1970 the contribution from the physician

totalled $26,086 and the Auxiliary $21,737. The total monies contributed in Indiana in 1969 amounted to $45,407 and in 1970 the total was $47,823.

The Association has received a letter from Dr. Robert Reid. If you will recall, we had a discussion relative to their obtaining space in the building for Medi-Tech. Also we discussed the rental of some of the property on Pennsylvania to them. Dr. Reid pointed out that, if they did lease the property on Pennsylvania or space in the building, he would be willing to negotiate a five-year lease but felt it would be necessary to spend some $25,000 to make the property on Pennsylvania suitable for their use and approximately $12,000 to prepare the headquarters building for their use.

The Executive Committee discussed all the possibilities and, speaking on a purely fiscal basis and not getting involved in the pros and cons, it is our conclusion that we would propose that they rent one of the Pennsylvania properties at the same rate which is now being paid to the Association and that they themselves make such improvements as they desire.

CHAIRMAN: What is the Board's feeling?

DR. WILHELMUS: You remember that the Committee on Finance gave a report on this and we felt that any negotiations for the leasing of this property should be made between Medi-Tech and the bank and not directly with this Association.

CHAIRMAN: Well, the question is: does the Association want to spend any money remodeling the properties? I believe the impression was that we were not to spend any money.

DR. WILHELMUS: That is correct.

DR. KERR: We do feel we owe them the courtesy of some sort of response. Are we saying if they want to rent it and fix it, then let them rent it and fix it.

DR. HOYT: I think Dr. Reid had asked that we verify now what the rates would be for renewal and last night we discussed in committee that we guarantee them a rate for five years and it must be renegotiated at the end of the five-year period.

OPINION

CHAIRMAN: In other words, I take it the Board wants the bank to handle the situation.

DR. KERR: Then the letter would say the letter had been referred to the bank and to discuss it with the bank.

The next matter referred to the Board was a letter from Dr. Jene Bennett, who most of you will recall as being a former councilor. The letter pointed out he does not think the association should subsidize members of committees and commissions for attending commission and committee meetings. He felt this was one place the association could save money.

COMMENT: Dr. Bennett should be advised that, if it is his desire, a resolution should be presented in the House of Delegates in October.

DR. KERR: We then had a request from RMP for use of the mailing list, the purpose of which was to send to all doctors a survey questionnaire that is in two parts. You have a copy of it and we suggest you look at it carefully.

RECOMMENDATION

It is the recommendation of the Executive Committee that we allow them to use the mailing list but that it be sent in their envelopes and Dr. Scamahorn would include with the mailing a note explaining that while we were interested in the results, this was not of our sponsorship.

DR. SCAMAHORN: In a conversation with Dr. Stonehill, I suggested that he prepare the questionnaire and we would refer it to our proper commission for review and study and Dr. Stonehill pointed out that time would not permit this, so I asked him to prepare this questionnaire so the Board would have a chance to review it and he has cooperated in getting this material to us. You have had the recommendation of the Executive Committee. I think it would be very worthwhile. Personally, I doubt that I would take time to fill out page 4 of the questionnaire.

DR. INGRAM: I have never seen this before but, just glancing through it, I am not sure the matter is any business of RMP and to my mind the general attitude has been probably not even to support RMP and particularly not for this sort of thing. I am personally opposed to it.

The matter was further discussed by Dr. Kerr, Dr. Ingram, Dr. Gosman, Dr. Santare, Dr. Clark and Dr. Thatcher.

MOTION

DR. HARSHMAN: I move that we reject the offer we received from RMP.

The motion was seconded by Dr. Clark. The matter was further discussed by several.

CHAIRMAN: If there is no further discussion on Dr. Harshman's motion, I will call for a show of hands on the motion. All in favor of the motion? I count eight. Those opposed? I count six and the motion is carried.

DR. KERR: The next item referred to the Board by the Executive Committee is relative to a meeeting to be held in Des Moines May 7-9. This is one of the four regional meetings to be held throughout the country by HEW on Foundations for Medical Care. You will note there is a $150 fee for a state society to cover attendance of six representatives and additional representatives may attend for a fee of $5 each. The registration fee does not include the expense of the banquet on Friday or the luncheon on Saturday. You will also note that any county society which has 50 or more members and sends a representative will incur the same cost as the state association, namely $150. However, for a county society having less than 50 members, the registration fee would be $25 plus an additional $5 for each additional representative attending from the county.

CHAIRMAN: My thought on this was we should have someone go for information purposes, but I thought we might go a less expensive way by letting one of our trustees who is from a small society go and then we reimburse him.

DR. KERR: The Executive Committee thought this was an important meeting and one in which we should have a representation.

The matter was further discussed by Dr. Harshman and Dr. Neumann.

DR. SCAMAHORN: My thought is that Dr. Petrich, who will succeed me as president in October, should attend this meeting so that we will have some continuity for the coming year. I think it is an important meeting and I really feel that Dr. Petrich and a trustee or someone interested should go.

CHAIRMAN: Considering the transportation costs, I do not think we need a large representation at this meeting. I think we could have one man come back and report to us and, if Dr. Petrich will go, we will send him from his county society.

The matter was further discussed by Dr. Scamahorn, Dr. Ingram and Mr. Waggener.

ACTION

CHAIRMAN: We will take it by consent then, if Dr. Petrich will go, we are going to let him pay his own way from his own county and then we can reimburse him the $25 plus travel and he is to report back to the Board. We will notify the other counties and let them do whatever they please.

DR. KERR: The Executive Committee also refers to you a notice of the AMA National Conference on Peer Review in Chicago May 21-22. Here is another meeting on a subject which certainly has been a sticky issue and will be for some years to come.

OPINION

It is the opinion of the Executive Committee that there should be in attendance at this meeting the president, president-elect and the executive secretary, plus a representative from the Commission on Governmental Medical Services, plus anybody from the Board who may want to go. This is a subject on which we should be well informed.

ACTION

CHAIRMAN: Then we will send the president, the president-elect, Mr. Waggener and the Chairman of the Commission on Governmental Medical Service. Is that all right?

DR. HOYT: I think this is one of the hottest things we have and one of the most important things and I think it wise that we send several.

After further discussion, it was also agreed to send Dr. Smith, Dr. Thatcher, Dr. Ingram, and Dr. Wilhelmus, in addition to the others, all to go at association expense.

DR. KERR: Another matter, as you know, the scientific portion of the annual meeting is to be handled now by the various sections and specialty groups. With that we got into some additional problems. We have a request from one section for honoraria for three speakers. We checked into the records for the last several years and it was the conclusion of the Executive Committee that we would recommend to the Board that a total of $1500 be used for speakers and this amount be given to the Commission on Convention Arrangements which would be given the responsibility of doling it out it these groups in whatever fashion they saw fit.

ACTION

CHAIRMAN: Unless there is objection, we will take this recommendation by consent.

DR. WILHELMUS: Mr. Chairman, when Dr. Kerr brought up the matter of RMP asking for the mailing list of the Indiana State Medical Association and it was referred to the Executive Committee, if a particular county society asks for the mailing list, is this automatically given to them or is this referred to the Executive Committee?

DR. KERR: I will ask Mr. Waggener to answer this question.

MR. WAGGENER: I have been instructed by the Executive Committee that all requests for use of the mailing list must be referred to the Executive Committee. The only exception is that under the Constitution and Bylaws we are required to mail notices of district meetings and this is automatic. We also, by recent action of this Board, agreed to distribute minutes and meeting notices for county medical societies if we were requested to do so by the county society. Otherwise, all requests for use of the mailing list are referred to the Executive Committee.

CHAIRMAN: We will now move to item 8, a letter from the Commission on Public Health. The letter points out that the Commission is in conversation with Dr. Offutt on strengthening local health departments. Pertinent to this discussion is the possibility of legislation being proposed to consolidate the 101 present Health Departments now in existence in Indiana into a smaller number. (No legislation proposed in 1971 session.) Dr. Johnson, Chairman of the Commission, desires the opinion of the Board concerning this proposal. They had no comment one way or the other and I would suggest that we turn this over to our Commission on Public Health and the Board liaison representatives, Dr. Hillis and Dr. Smith.

The letter also contains excerpts from the minutes of the Commission meeting held January 17 regarding resolution 70-13, Physical Examinations for School Employees, which dealt particularly with TB testing. The Commission concluded that the intention and clarity of the law would be helped by striking out the word "physical." It was felt that the bill was for TB control and did not intend this to be for a physical examination. The Commission moved that the resolution be referred back to this Board with this interpretation.

DR. HARSHMAN: The February minutes of the Commission make reference to the lack of action by the Board on this statement you just read. I am not sure in my mind what kind of action they want.

CHAIRMAN: I interpret this to mean they want to know whether we approve this or don't approve it, so all those who approve this will say so by a show of hands. The Commission at this time states they believe the intention and clarity of the law would both be helped by striking out the word "physical."

DR. HARSHMAN: I approve of what he says but I still am not sure in my own mind how this is going to change the law or the interpretation thereof.

MR. WAGGENER: What I think they are recommending is that the word "physical" be stricken out of the law by introducing such a law in this session or the legislative session in 1972.

MOTION

DR. HARSHMAN: I then move that we do accept this recommendation to strike out the word "physical."

The motion was seconded by Dr. Schauwecker, put to vote and carried.

(Legislation doing this was passed by the 1971 General Assembly.)

CHAIRMAN: About the Public Health Departments, I feel we want to think about this a little bit and let Dr. Smith and Dr. Hillis give us a report at the next meeting.

DR. CLARK: I am the Board Liaison representative of the Commission on Special Activities and the Commission on Constitution and Bylaws. These two groups have been having meetings and I do not know when they are having meetings as I have never received a notice of such meetings. I think we should be advised as liaison representatives when these Commissions meet.

DR. SANTARE: I will second that about the Commission on Medical Economics and Insurance. I have not received a notice of the meetings.

CHAIRMAN: Jim, will you personally see when these commissions are meeting that these fellows are put on the list and sent a notice.

COMMENT: I believe the members of the Board should have a report of the attendance of representatives from their respective districts so we will know who is attending the meetings and who is not attending.

CHAIRMAN: This will be done. We have a letter from the Society of Internal Medicine stating that they have a vital interest in their group being represented on the Board of Blue Shield and hope that this Board will keep this in mind when nominations are made for membership on the Board of Blue Shield. The Society of Internal Medicine would like to have George Willison of Evansville on the Board and Dr. Hugh Steele of Lafayette as a second member at large. We will take this as a matter of information as this will not be up for Board action until the January 1972 meeting.

CHAIRMAN: I ask you all to take as a matter of information the complete tabulation of the final results of the survey. Are there any comments?

MR. WAGGENER: I would like to ask a question at this point. My office is bombarded with proposals for tours. Shall I now refer these to the Executive Committee to decide whether or not the Association wants to sponsor any of these tours? What shall the action be as far as the secretary is concerned?

CHAIRMAN: I see no objection to referring these to the Executive Committee and they can turn them down real easy but if something comes along that looks

real good they can then bring it to the Board.

MR. WAGGENER: The last action of this Board was that this association would not sponsor tours—period. Therefore, I feel if you are interested in sponsoring tours, and following the recommendation of the membership, with 66% of all those replying indicating they were interested in the association sponsoring such tours, I see no reason why we cannot consider these offers, but as of today the association is on record as not sponsoring tours and I believe you will have to reverse your decision if you find something the Executive Committee and this Board feels is worthwhile.

MOTION

DR. WILHELMUS: I have sympathy for the cause of surveys; therefore, I make the motion that the Executive Committee study these tours and bring any recommendations to this Board.

The motion was further discussed by Dr. Schuster, Dr. Wilhelmus and Dr. Gosman.

CHAIRMAN: The motion was seconded by Dr. Clark. All in favor say "aye" and, opposed, same sign. The motion is carried.

DR. KERR: We have received a letter from one of our members in response to the questionnaire which I would like to read to you.

DR. SANTARE: I think this letter, although not directed to the editor of *The Journal,* was very well put and I think the answer is well put too. I think having them published in *The Journal* might be of some benefit to all physicians in Indiana.

RECOMMENDATION

CHAIRMAN: Is there any objection to having the letter and the answer published in *The Journal?* Of course we will have to have the permission of the writer to do so. If there is no objection, Dr. Ramsey, will you take care of this?

DR. INGRAM: I think that is a good idea. He makes some excellent points and one of the things we have failed to do, and I am not denying that attempts are made, but not very successful. I wonder if we should not reassess some of our tactics in getting pertinent information to the public. It seems like every communication media blames the doctors for the high cost of medical care and the high cost of government programs on medical care. Yet we realize that about 9—11% of the Medicare and Medicaid costs goes to the physician. The fact remains, with the current rate of inflation, if doctors give their services to these groups, it would not appreciably alter the cost to the government of providing the program. This is not, I think, generally known by the people of Indiana or the people of this nation. The figures are available from the government which points out the slice of the pie which the physician gets and how much the hospital and nursing home and other providers receive under these programs. I think his points are well taken and I just throw this out for people to think about. I doubt if the patients in your individual practice are aware of what percentage of the government dollar you get.

DR. CLARK: I think each trustee should have a copy of this chart showing the percentage of the Medicare and Medicaid dollar received by physicians and others.

MR. WAGGENER: If we can borrow the copy we can duplicate it immediately so you may have a copy.

DR. NEUMANN: I would like to make one comment. The Commission on Medical Economics and Insurance has been delving into such problems as the Foundation, malpractice, and other types of insurance in depth. Here you have questioned and about 50% of the members replied. About one-half of those who replied indicated they were interested in all forms of insurance. They are interested in this malpractice thing we found out but it seems out of the question in getting an opinion about obtaining a malpractice plan. The disability program is doing well and I previously reported this to this Board in a letter. The life insurance program is doing well. We have now been approached regarding whether the State Medical Association would be interested in providing group automobile insurance. We do not want to delve into this unless we have the Board of Trustees' permission to look into this matter. I would ask if you do wish the Commission to look into this matter. Shall we bypass the offer? Do you want us to look into it and report back to you?

CHAIRMAN: I would suggest that you look into it and report back to this Board.

MOTION

DR. SCAMAHORN: I move that the Commission be given full authority to investigate and report regarding automobile coverage for the members.

CHAIRMAN: The motion has been seconded by Dr. Wilhelmus. All those in favor vote the usual sign—opposed, the same. The motion is carried.

DR. NEUMANN: I would like to point out that the company making this proposal would like to, at their expense, survey the membership to see whether or not a sufficient number of our members is interested in this type of program. I would also like your feeling on permitting this company to survey our members, at their expense, as to whether or not the membership is interested in this type of program.

OPINION

CHAIRMAN: What is the feeling of the Board of Trustees? Do you feel that the president should write a covering letter and should we hereby say we give the company permission to do these things after we review it as a Board of Trustees?

DR. NEUMANN: You mean the Commission shall review it?

CHAIRMAN: That is right. If the company wants to do it, let them do it.

DR. NEUMANN: With the Commission on Medical Economics and Insurance providing a covering letter?

DR. SCAMAHORN: I think you almost have to have a covering letter to make it valid.

CHAIRMAN: We will now move to item D. We went to HEW during the trip to Washington and talked to a director of HMO and I learned absolutely nothing. Maybe someone else has other comments.

DR. SCAMAHORN: We talked with a Mrs. Myers who is charged by HEW to run the HMO program. I don't know but I have an idea she has a Ph.D. in Social work. Dr. Jeff Davis, who has been on the HEW staff a short time, and two others were present at the meeting with us but she did most of the talking. She made it clear that Kaiser Permanente and the San Joaquin Valley are the models for HEW. They discussed the possibility of seed money to get HMOs going, such as 40 million dollars. There is a definite interest on the part of HEW in this program. Then she discovered all in attendance were G.P.s except Doctor Hoyt. Joe Black was there and of course the biggest city represented by a G.P. was 10,000. We said, "What is the ideal group?" and Mrs. Myers replied, "Well, theoretically, the ideal group is a population of 10,000 patients and 10 doctors." I pointed out that my county has 50,000 and there were roughly 17 doctors serving the whole county. "Oh," she replied, "that is too many patients," and I said, "What are you going to do with them?" This was about the tenor of the whole meeting. They really don't, in my opinion, know where they are going but they have a group already stumping HMOs and there are groups ready to go and have money. As you know, there are one or two groups privately doing it here. In my opinion it was a very interesting meeting although we found out very little.

I would like to point out to you that

while in Washington we definitely got the impression that Congress is not buying Nixon's proposal. They have a feeling that even it is too liberal. The Medicaid bill —we have five of our representatives now on the bill—and they said they think it is not too disruptive to health care in this nation. The main thing all of them are talking about is—let's not try something that is such a "pig in a poke."

CHAIRMAN: Thank you. We will now move to item E, Report on Legislative Activities.

MR. WAGGENER reviewed the status of legislation in the 1971 General Assembly and detailed some of the activities of the staff with respect to many bills currently being considered.

DR SCAMAHORN: I yould like to say, on behalf of myself, I want to thank Jim and the three boys primarily, along with Jim, as they have done a tremendous job and really we are coming out real good so far, thanks to these men. I think they have done one of the best jobs and I think you must consider with an annual session you know we are pulling our field men out of the territory to cover these sessions and, as someone has said, "if we don't we are going to get beat in the legislature," and that is right. But with annual sessions you are going to dilute the field secretaries' work every year and I think this is something the Board should look at with yearly sessions, if we are going to pay attention to the legislature, it is going to cost a little more money.

CHAIRMAN: We might then be in the process of getting another field man.

CHAIRMAN: Item F, Report of the Commission on Constitution and Bylaws. It is in your agenda book. Are there any comments?

The report was discussed by Dr. Harshman, Dr. Dukes, Dr. Scamahorn, Dr. Clark and no action was taken.

CHAIRMAN: We will now move to item 9, Unfinished Business. Report of the Committee on Health Careers.

DR. SANTARE: I understand this has been delayed because I was not present for the last meeting of the Board of Trustees. As a result of our investigation, I think Health Careers has been more active in informing us as to exactly what they are doing in the state and in my view it has been good. They had a meeting, along with Comprehensive Health Planning, which was a seminar on Health Careers, which was well attended and I thought well presented. I think the committee feels that in this particular case Health Careers is doing a good job and is entitled to our continuing support.

On the other hand, I do not believe that Health Careers is entitled to any more financial support than any other good organization working within Medicine. I think the main point was that they wanted more money from us.

MOTION

DR. SCHUSTER: I understand that for several years we have not given this group any money and if this is the primary issue before the Board, I would therefore move, in order to focus right down on the problem, that we give evidence of your committee's support of their activities in a tangible fashion, by awarding them $1,000 per year support.

The motion was discussed by Dr. Santare and Mr. Waggener.

AMENDED MOTION

DR. SCHUSTER: In view of the discussion, I will change my motion to read $500. I still thought it was $1,000 which the House had voted previously.

The motion was discussed further by Dr. Dukes, Dr. Santare and Dr. Gattman.

ACTION

CHAIRMAN: The motion has been made to give the $500 on a one-time basis and that the request for funds to this organization be reviewed annually. All in favor say "aye"; opposed, same sign. The motion is carried.

CHAIRMAN: We will now go to item 10.

DR. SCAMAHORN: As you know, you approved the establishment of an Ad Hoc Committee, at no expense to the association, to be composed of practing physicians, to study maternal and child care problems. Dr. Sprague Gardiner took the chairmanship of the committee and today he has a report for this Board.

I have attended all but one of the meetings and I am greatly impressed with the fact that it is primarly composed of practicing physicians and there is input from the Medical School and the State Board of Health. Therefore, I would like to have the pleasure of introducing to this Board, Dr. Gardiner and the other men involved with him in this activity. To Dr. Gardiner's right is Dr. Jack Higgins, who represents General Practice and is from Kokomo. To his left is Dr. Verne Harvey, representing the State Board of Health; and Dr. Morris Greene, Department of Pediatrics at the University. I will now ask Dr. Gardiner to give his report.

DR. GARDINER: I have requested the privilege of presenting this proposal of the ISMA Ad Hoc Committee on Maternal and Child Care because we would like to have the endorsement of the Board of Trustees so that the project may be implemented at the earliest possible date. As you will remember, we requested permission to form this Ad Hoc Committee consisting of practicing physicians of the state society and consisting of family practitioners, obstetricians, pediatricians and a representative of the State Board of Health. This Indiana Perinatal Care Project, the details of which you have before you, is an educational program which will be conducted at no expense to the State Society. New knowledge and skills have been developed in the field of perinatal medicine which, if appropriately applied, have the potential of reducing the infant mortality rate by 50%.

There are several phases of this project. We will continue to make a detailed demographic and epidemiological study of obstetric and pediatric care so that data can be developed county by county. Second, we want to conduct an educational survey of the current facilities for caring for high-risk mothers and high-risk infants. Third, we would like to analyze the already existing patterns of referral of high-risk mothers and high-risk babies so that any regional concept may amplify the regional concept already established by practice.

We plan to establish a comprehensive Perinatal Care Center at the Indiana University School of Medicine which will be under the direction of Dr. Gresham, a former family practitioner from Indiana who, after taking a residency in pediatrics, has for the last several years been associated with the perinatal unit at the University of Colorado School of Medicine. Once the comprehensive Perinatal Center has been established, it would encourage physicians and nurses from various areas of the State to spend varying periods of time at the Center learning the new knowledge and skills of perinatal medicine.

As you will see from the proposed program, we will continue the collection of statistical data so that the logical locations for other perinatal centers throughout the State can be identified.

Reports will be made to the ISMA Board of Trustees regarding our progress and, when recommendations have been developed, they will be presented to you for transmission to the Reference Committees of the House of Delegates so that all physicians will be knowledgeable of and able to participate in future maternal and child health care in Indiana.

Dr. Verne Harvey has participated actively in the development of this project and is of the conviction that the Board of Health would look favorably upon a request from the State Medical Association for funds for a grant to implement this study.

I would like to call upon Dr. Morris Green, a member of our Committee, to say a few words on behalf of this project.

DR. GREEN: One of the most urgent demands for education in the state, from my point of view, is in the area of perinatology. In every corner of the state general practicioners, pediatricians, obstetricians, are really concerned about the need to develop model centers. There are now certain guidelines published by the American Academy of Pediatrics which make it really mandatory to provide a certain level of care, and I think one of the things we are trying to do at the university—and we have been planning this for a number of years—is to make it a primary focus of education throughout the state. I think we will do it in many ways. We, first of all, in training new people who are coming out, have 25 health officers now who will be trained along these lines more intensively. We will also be developing a specialist in this area who will go to the major areas and, say, help develop centers there. We would also like to offer training programs whereby physicians and nurses can come down and spend a day a week or more intensive periods of time to learn these new techniques. Now I think that Dr. Gresham, who has been mentioned, has been in general practice, and I think that is probably why he is interested in perinatology. He wants to do not just the baby or child. He would also like to pay attention to the mother, and he has this kind of background. I think perinatology is kind of a natural for a person with this kind of interest. He has also had experience with the development of a statewide plan in Colorado. I think the exciting thing about this program is that, to my knowledge, it is the first one that would be developed under the auspices of a state medical association. I think the Indiana State Medical Association would become a national pacesetter in this fast moving field and I think we would have a model that could be copied elsewhere throughout the country. So it is very exciting. It is one of the most timely things, from my point of view, that can be developed and I think that Indiana can in this area really lead the nation. Thank you.

The report was discussed by Dr. Clark, Dr. Gardiner, Dr. Scamahorn and Dr. Harvey.

MOTION

DR. SCAMAHORN: I move that the Board of Trustees give authorization to me or to Dr. Gardiner as the appropriate person to apply for money for this project from the Indiana State Board of Health.

The motion was seconded by Dr. Wilhelmus, put to vote and carried.

CHAIRMAN: We will now move on to item B, the matter of our relationship with RMP. I don't know why it is on the agenda at this time.

DR. INGRAM: I would assume the reason that it is back on the agenda is because at the last meeting of this Board it was brought up and the discussion was tabled until Dr. Gosman could be present.

CHAIRMAN: Thank you. Have you had some time to think about it, Dr. Gosman?

DR. GOSMAN: I have thought about it for months and don't think I need any more time. I will make it as brief as I can.

MOTION

A motion was duly made and seconded to remove the question from the table and bring it back for discussion.

DR. GOSMAN: I will start by saying I feel that for the State Medical Association to withdraw their support at this time would be in error. If I may give you a little bit of what has transpired since the Joint Meeting of the Executive Committees of the Association and RMP, which most of you may be aware of, but funds have been tremendously curtailed, in fact withdrawn to where we have had to operate on 80% of previously proposed budgets. No additional monies seem to be forthcoming at this time. "We" is RMP. I am speaking as a member of the Executive Committee of RMP as well as a member of this Board. There have been many meetings held during the last month by the Executive Committee of RMP and the Board as to just what our future is. As a matter of fact, this is in discussion at this time. There is some feeling that RMP will become sort of a Medical Advisory Group. There seems to be, in my judgment, thoughts of phasing out this program coming from Washington.

CHAIRMAN: In other words, you think we ought to just sit back.

DR. GOSMAN: I do.

CHAIRMAN: Any other comments?

DR. GOSMAN: That we do not withdraw at this particular time.

CHAIRMAN: Well, shall let it die?

DR. GOODMAN: I have a question of Dr. Gosman. I wonder if, from his experience, he is prepared to comment on the present status of the relationship between RMP and Comprehensive Health Planning. Whether either or both might survive and carry a function of the other. Is that an unfair question?

DR. GOSMAN: It is not an unfair question. Perhaps some of the others here who have been attending more of the Comprehensive Health Care meetings can better answer that. There was a meeting held last Wednesday or Thursday which I was unable to get to but my own feeling, Dr. Goodman, is that both perhaps may have trouble surviving.

The matter was further discussed by Mr. Waggener, Dr. Scamahorn, Dr. Schuster and others.

ACTION

CHAIRMAN: I take it then that we will just let it rest. If there is no objection we will move on to item 9c.

We have been requested by the Blue Shield Board and the Executive Committee of Blue Shield to consider enlarging the Blue Shield Board. I feel that since the Ad Hoc Committee on Relationship Between Blue Shield, Physicians and County Medical Societies has not finished its work that this should be taken under advisement and brought back to the next meeting and I would like to appoint Dr. Santare, Dr. Wilhelmus and Dr. Butler to go into this matter and give the Board a factual report at the next meeting. If there are no objections to this appointment we will move to 9b, part 2.

This was the matter that was also deferred concerning the appointment of two of our members to two committees on RMP.

DR. SCAMAHORN: They are asking for two members to be appointed from the State Medical Association for membership on committees of RMP.

DR. GOSMAN: If I may add, the Planning Committee was the one that has come out with this questionnaire that they have asked be sent out. I would actually support the appointment of members to that particular committee from the State Medical Association and so move.

MOTION

CHAIRMAN: Dr. Gosman has moved that we go ahead with the appointment of representatives to the committee. The motion has been seconded by Dr. Goodman and I would like to have a show of hands on this vote. All in favor—I count ten. Opposed? The motion is carried. Anyone have any suggestions on appointments?

The suggestion was made that Dr. Wilhelmus and Dr. Hillis might be considered.

CHAIRMAN: Dr. Scamahorn, you have heard the recommendation, you will appoint them.

DR. SCAMAHORN: We have invited the osteopaths and they are here. I would suggest that they lunch with us.

MOTION

CHAIRMAN: Before we get away from Peer Review, Dr. Ingram states he and Dr. Wilhelmus will go. Do I have Board approval to pay their expenses?

DR. SCAMAHORN: I so move.

The motion was seconded by Dr. Goodman, put to vote and carried.

The representatives of the Indiana Osteopathic Association then presented themselves before the Board, including Mr. Woods, their attorney; Dr. McCormick of Elkhart, who acted as spokesman; Dr. Hall from Kendallville, Dr. Hinton of Nappanee, Dr. Wolfe of South Bend, Dr. H. Dearing Wolf of Indianapolis, Dr. Thomas Rymers of Osceola and Dr. Scott of South Bend.

DR. McCORMICK: Medicare has been operating long enough that most of the physicians' offices and most of the hospitals which handle the billing seem to abide pretty well by the rules. In our area most of us have more difficulty with Medicaid problems than those of Medicare. One of the chief problems is based on the fact we have a hard time convincing old people that Medicare does not provide all that they think it provides. I would like to ask Dr. Hinton to discuss the Peer Review aspect.

DR. HINTON: I see that this organization is interested in Peer Review and you do have some five or six men going to a national meeting on this subject to represent this association. Peer Review is here. It is going to be one of the problems at the national level with HEW and with planning committees. It also will be a problem with the insurance carriers. Frankly, it is our belief we must have Peer Review. We think that both professions should try to work out some type of program similar to the Missouri Plan which, in our opinion, does have merit. Missouri has a 12-member Peer Review Committee represented by nine members of the medical profession and three representatives of the osteopathic profession working as a whole. Somehow I think our professions will be mistaken if we fail to adopt such a plan, because, gentlemen, if we don't third parties are going to do our Peer Review for us and I am sure that both of our groups want to be in a position to perform Peer Review for our own professions. I know there are other professions in the health care field who are quite interested in becoming primary physicians; family physicians; etc., so, therefore, it behooves both professions who hold an unlimited license to practice medicine, surgery and obstetrics in the State of Indiana to handle our own Peer Review.

CHAIRMAN: Are there any other comments? I notice you have listed the question of compulsory national health insurance. Do you have something on this?

DR. McCORMICK: Just to narrow it down to three which we know about. There is the Kennedy Plan, which is a give-away plan. We feel that the Federal government under this will have the final say of everything and we will have very little to say. Third parties will be the strongest of the groups. We have the President's Plan, part of which, I believe, will be paid by fees other than Federal funds. Then the next one is the AMA Plan which allows the insurance companies to take over and to work out some workable plan. The amount of people currently on welfare whom we see, and the total number of people we see under federal care already, it could be a real battle for all of us to hold down some of the things which are going to occur. I feel most of the people think the Kennedy Plan is most worthwhile but I am sure most of us do not believe that way. I wonder if we might ask what your group's feeling is on some of these.

DR. SCAMAHORN:I would like to give a little background some of you may have forgotten. Dr. Wolfe, as secretary of the osteopathic group, wrote us a letter suggesting that we meet jointly and, as you know, this Board did approve that I answer the letter in the affirmative and so these people are here as our guests.

The first step in developing some liaison and inter-professional relationship between our two groups, with our associations representing the practicing physicians in the State of Indiana, we should discuss our mutual problems.

With the effort of these gentlemen, we are talking about an additional 400 doctors who are rendering health care to the public of our state, just as we are. Now about Medicare and Medicaid, we have just had our Congressional visit and we have the impression in talking with HEW, our delegation and everyone else, that they are not happy with these two programs but they don't know the answer either. As you have said, and I think clearly so, the National Health Insurance concept has been an attempt to replace these two programs. Nixon did have the approach of HMOs; and the Kennedy Plan, as you say, is a total giveaway. The Medicredit AMA bill is an attempt to perhaps keep the same health care structure, the system which we presently have and under this program we are talking only of financing. Some of the men and women in Washington agree that one of these is going to be in the final plan. They don't know what it will be but our stand, gentlemen, is under Medicare and Medicaid—these are a poor approach to the Health Care System. It has failed. We, as physicians, are being kicked and accused; it is our fault that these plans are not working. We know this is far from the truth.. Thirdly, money isn't the only answer to health care problems in America. The AMA has taken a stand nationally that there are many other problems and you have mentioned some of them. The health care system is a complicated one and no one facet completely solves the problem.

While in Washington I got the impression that our Indiana Senators and our Representatives were not in favor of the Kennedy Plan—even the most liberal of the Democratic representatives. I think most of them felt the Kennedy program was not the approach but they had no answer themselves.

On compulsory national health insurance, we are opposed to anything that is compulsory. This is out, as far as we are concerned as an organization. On professional liability programs—we have just concluded a symposium on this subject. Our speakers pointed out there is no way for premiums to go but to go up and that malpractice is a medical, legal, economic and social problem. There were two suggestions given: (1) There should be some quality control to the practice of medicine. This was imperative. (2) Besides quality control there has to be some approach made in the medical insurance field. And one of the expenses of liability insurance was the money spent for defense and that there should be a common carrier for both doctors and hospitals to reduce this expense and due to the fact that 95% of all suits originate in hospital services.

Another approach discussed was that of compulsory arbitration. Of course, you understand that compulsory arbitration is the program in which the results are binding upon both parties. These are problems which are common to both your association and ours. I apprcciate the fact that the osteopaths took the initiative in writing us a letter and I would be very happy to have more interplay between their organization and ours.

DR. HINTON: Along that same line and in order to expedite matters, I think the main reason for the meeting here today was to explore lines of communication to be established so we might have contact with each other. It is not fair to this Board, with the busy schedule ahead of it, to brief us on their stands. I do not think that is necessary. I would, however, like to see if it is possible for us to establish a Conference Committee between the Indiana State Medical Association and the Indiana State Osteopathic Association so that we might have a means of communicating with each other on subjects of common interest. I think if we do that we will have accomplished miracles. For two professions which hold the same type

of license to practice in the same field, it is essential for both your association and mine that we work together in these areas which threaten our very existence. So, as you said, Mr. President, if our two professions can communicate, I think this is the important decision to be made. Thank you.

DR. SCAMAHORN: I want to say personally and on behalf of the association: thank you for being here. You are welcome to come. I think we will probably prepare some type of committee which would be available to meet with a like committee of your organization. Your appearance here very definitely shows us you are interested. We are interested, so I think you can take it as such.

DR. KERR: Before they leave, I think it would be pertinent for everybody to recognize this. Of all the offices we visited, Congressional, Senatorial, and bureaucratic, everyone said that the number one domestic issue throughout this session of the Congress and particularly in the next election is going to be health, health care, and health plans; and, while there are no commitments as of this time, if you think our groups are not in the same barrel this next time around, you are mistaken, gentlemen.

CHAIRMAN: Thank you again, gentlemen.

The Board then went into Executive Session.

There being no further business, it was agreed to meet again at 8:30 a.m., Sunday, June 13, with the delegates to the AMA for the purpose of discussing the usual business and the matters to come before the AMA House of Delegates.

EXECUTIVE COMMITTEE

March 27, 1971

The Executive Committee convened in the Headquarters office at 6:00 p.m. Saturday, March 27, 1971.

Roll call showed the following: Donald M. Kerr, M.D., chairman, present; Malcolm O. Scamahorn, M.D., present; Peter R. Petrich, M.D., absent; Joe Dukes, M.D., present; Lester H. Hoyt, M.D., present; Wilbert McIntosh, M.D., absent; Hugh K. Thatcher, M.D., present; Frank B. Ramsey, M.D., present and James A. Waggener, present.

MINUTES OF THE MEETING held January 30, 1971, were approved by consent.

MEMBERSHIP REPORT as of February 28, 1971, was approved by consent.

Membership report as of February 28, 1971:

Number of members as of December 31, 1970	4,505
1971 members as of February 28, 1971:	
Full dues-paying members	3,398
Residents and interns	57
Board remitted	46
Senior	373
Honorary	3
Military	34
Total 1971 members as of February 28, 1971	3,911
Total 1970 members as of February 28, 1970	4,049
Number of AMA members as of December 31, 1970	4,337
1971 AMA members as of February 28, 1971	3,652
Full dues paying	3,199
Exempt, but active	453
	3,652
Number who have paid state dues but not AMA dues as of February 28, 1971	199
Number who paid state dues but not AMA as of December 31, 1970	168

Headquarters Office:

XEROX PROPOSAL—The secretary presented a proposal from Xerox for the installation of a "7000" piece of equipment. On motion of Drs. Scamahorn and Hoyt, the installation was approved.

SURVEY BY MEDI-TECH—A letter was read from Medi-Tech stating that they had computerized and tabulated the survey on abortions and other matters at no cost to the association.

On motion of Drs. Scamahorn and Dukes a letter of appreciation is to be written to Dr. Robert Reid for this service.

LETTER FROM GEO. S. OLIVE & CO.—A letter from George S. Olive Company, the association accountants, was read dealing with certain changes which they recommended in the handling of various bank accounts and the changes were approved on motion of Drs. Hoyt and Dukes.

CHP PHONE AT BLUE SHIELD—The secretary asked a question concerning the phone which the association is paying for but installed at Blue Shield for use under the Comprehensive Health Program and said it was his understanding it was not really being used and should be taken out.

The removal of the phone was approved on motion of Drs. Dukes and Scamahorn.

PROPOSAL FROM INDPLS. POWER & LIGHT CO.—A proposal was read from the Indianapolis Power & Light Company about revising the type of billing on electrical service. A change in billing for one year trial was approved on motion of Drs. Dukes and Scamahorn.

BUILDING REDECORATION—A bid was presented for redecoration of the building from Zaborek. The bid was approved for the redecoration on motion of Drs. Scamahorn and Hoyt.

SURVEY ON EXHIBITORS—A survey of the attitude of exhibitors at the South Bend meeting was reviewed for the information of the committee.

HONORARIUM FOR SPEAKERS IHA-ISMA CONFERENCE—The secretary raised the question concerning the payment of an honorarium for speakers appearing on the program of the joint meeting of the ISMA and IHA. On motion of Drs. Scamahorn and Dukes, the secretary is instructed to pay an honorarium of $100 per speaker.

THE TREASURER GAVE A REPORT for the period ending February 28 which was approved on motion of Drs. Hoyt and Scamahorn.

LETTERS OF THANKS—Letters of thanks were read from many youth organizations expressing their appreciation for the part the association played in helping this effort by contributing to the Indiana Youthpower Conference.

LETTER REGARDING LIABILITY INSURANCE—A letter from the association's insurance broker recommending increasing the association's liability coverage from one to three million dollars was read and the increase was approved on motion of Drs. Scamahorn and Dukes.

CONTRIBUTIONS—AMA-ERF—A report of the contributions received from physicians and the Woman's Auxiliary for the AMA-ERF for the year 1969-1970 was reviewed for the information of the committee and referred to the Board for its information.

LETTER FROM MEDI-TECH—A letter from Medi-Tech, Inc., concerning the leasing of the property located on Pennsylvania Street was reviewed and, on motion of Drs. Scamahorn and Hoyt, this was referred to the Board of Trustees with the recommendation that Medi-Tech be granted a lease for a period of five years at the present rental rate and that any alterations necessary be at the expense of Medi-Tech, Inc.

LETTER FROM MRS. W. C. BOND—It was called to the attention of the committee that Mrs. Johnnye Bond, widow of Dr. Walter Bond, had originally requested a refund of the $50 loan for the construc-

tion of the association building but had returned the check as a contribution to the association.

LETTER FROM DR. JENE R. BENNETT—A letter from Dr. Jene R. Bennett expressing the belief we should not pay travel expenses for those members of commissions and committees was read and the matter was referred to the Board of Trustees.

LETTER FROM DR. NELSON WOLF—A letter from Dr. Nelson Wolf setting forth his opinion as to several activities upon which the association should focus its attention was reviewed and the chairman of the Executive Committee assumed the responsibility for preparing a reply to Dr. Wolf's letter.

IRS REPORT ON FEES—An item appearing in the Journal of the Indiana State Dental Association concerning an IRS chart showing the average business net profits for physicians, osteopaths, dentists, chiropractors, lawyers, engineers, architects and C.P.A.s was reviewed for the information of the committee.

LETTER FROM BLOOD BANK—A letter from the Community Blood Bank of Marion County concerning the policy or position of the association with respect to state control for plasmapheresis was read for the information of the committee, and the secretary instructed to inform them we have taken no position.

LETTER FROM DAVIESS-MARTIN COUNTY SOCIETY—A resolution adopted by the Daviess-Martin County Medical Society voicing objection to Federal PSRO was read for the information of the committee.

LETTER TO STATE INSURANCE COMMISSIONER—A letter addressed to the State Insurance Commissioner by Dr. Gillen was reviewed and, on motion of Dr. Scamahorn, this is to be given to the Commission on Medical Economics and Insurance.

MEMBERSHIP U.S. CHAMBER OF COMMERCE—Renewal of the annual membership in the U.S. Chamber of Commerce was approved on motion of Drs. Scamahorn and Dukes.

REQUEST FOR MAILING LIST BY HEMOPHILIA FOUNDATION—A request for use of the mailing list by the National Hemophilia Foundation was approved by consent.

LETTER FROM INDIANA HEALTH CAREERS—A letter from Indiana Health Careers was reviewed for the information of the committee.

MARION COUNTY OEO—The proposed Marion County Program in OEO and Model Cities and a letter from HEW concerning HMOs was reviewed for the information of the committee.

MEMBERSHIP IN INDIANA PUBLIC HEALTH ASSOCIATION—Renewal of membership in the Indiana Public Health Association was approved by consent.

WEST VIRGINIA STATE MEDICAL ASSOCIATION LETTER—A letter from the West Virginia State Medical Association announcing the candidacy of Dr. Carl Hoffman for president-elect of the AMA was read for the information of the committee.

LETTER FROM DR. E. L. HOLLENBERG—A letter of inquiry from Dr. E. L. Hollenberg concerning the use of physician's assistants and nurses in his office and describing their duties was reviewed and the secretary is to inform him that all the acts which he proposed to have these people perform, the physician was still wholly responsible for their acts and results.

REQUEST FOR MAILING LIST BY RMP—The request from RMP for use of the mailing list in distributing a questionnaire was reviewed and it was the opinion of the committee that it was too lengthy and much of the information listed would not be available. On motion of Dr. Scamahorn, it was voted to refer this to the Board of Trustees with the recommendation that the association cooperate in this matter but the mailing not be made in association envelopes and that the president be authorized to write a letter to accompany such survey.

BLUE SHIELD MATTERS—Minutes of the Executive Committee of Mutual Medical Insurance meeting held January 24 and the minutes of the meeting of the Board of Directors held on the same date were reviewed for the information of the committee.

BLUE SHIELD PAYMENTS TO EMERGENCY ROOM PHYSICIANS—The president reported on several discussions he has had with respect to payments by insurance companies to emergency room physicians and by consent this matter is to be referred to the Commission on Medical Economics and Insurance to investigate.

UTILIZATION PATTERNS—The president discussed the comparisons he had received from Blue Shield with respect to utilization patterns of several physicians in Indiana and, by consent, this matter was referred to the Board of Trustees.

LEGISLATIVE MATTERS—Legislative matters were not discussed in detail inasmuch as a detailed report is to be made to the Board at its meeting on March 28.

THE JOURNAL—The question of ordering additional copies of the May issue of *The Journal*, which will be an issue on drugs, for distribution to all schools in the state and this was authorized on motion of Drs. Dukes and Hoyt.

G. P. SECTION REQUEST—In accordance with the previous action of the executive committee, the G. P. Section requested approval for three speakers from out of state to appear on their program during the October meeting.

The question then arose as to how much would be spent for speakers and how it would be divided. On motion of Drs. Dukes and Scamahorn, this subject is to be referred to the Board of Trustees with the recommendation that $1500 be allocated for speakers' expense and that it be left to the Commission on Convention Arrangements to determine how the funds will be split among the various specialty groups.

Future Meetings:

Fifth National Congress on the Socio-Economics of Health Care in Las Vegas April 2-3, 1971—the president was authorized to attend at a previous meeting and no additional authorizations were made.

AMA Conference on Long Term Care—A letter of invitation for reservations to be sent to the AMA Conference on Long Term Care to be held in Chicago on May 25 was read and it was determined that no representative would be sent.

Iowa Medical Society—An invitation to the president and secretary to attend the annual meeting of the Iowa Medical Society in Des Moines April 25-28, has been received and the president and secretary have sent regrets.

Ten Central States Medical Executive Seminar in St. Louis May 1—The secretary was authorized to attend and take the male staff to this meeting.

Student American Medical Association Annual Convention—An invitation has been received for the association to send an official representative to the annual convention of the Student AMA to be held in St. Louis May 4-8, and the secretary is instructed to send regrets.

By the same token, it was felt that the local Chapter would no doubt request funds to send delegates to this meeting and by consent it was agreed to designate a sum not to exceed $500 for this purpose, if requested.

Regional Conference on Foundations for Medical Care—The Regional Conference on Foundations for Medical Care is to be held in Des Moines May 7, 8, 9 and the question of representation was referred to the Board of Trustees.

AMA-AHA Conference on Patient Safety—A notice of the AMA-AHA Conference on Patients' Safety to be held in Chicago

May 13-15 was reviewed and no representative will be sent.

AMA National Conference on Peer Review—The AMA National Conference on Peer Review to be held in Chicago May 21-22, this is to be referred to the Board of Trustees with the recommendation that the president, president-elect, Chairman of the Commission on Government Medical Services and the Commission on Medical Economics and Insurance, along with the secretary, be authorized to attend.

Interstate Compact on Mental Health—The Interstate Compact on Mental Health to be held in Washington, D.C. May 2 was reviewed and no representative will be sent.

Attention was called to the AMA Annual Meeting to be held in Atlantic City June 20, 1971.

REQUEST FROM IHA—A request from the Indiana Hospital Association to name a person to become a member of their Research Council was read and, by consent, it was agreed that a staff member of the association represent the association at such meetings.

There being no further business, the meeting adjourned to meet again at 1:30 p.m. Saturday, June 12, without lunch, and an interim meeting of the committee will be called if felt necessary by the chairman of the committee.

The above minutes were approved in each separate part and as a whole on June 12, 1971. ◄

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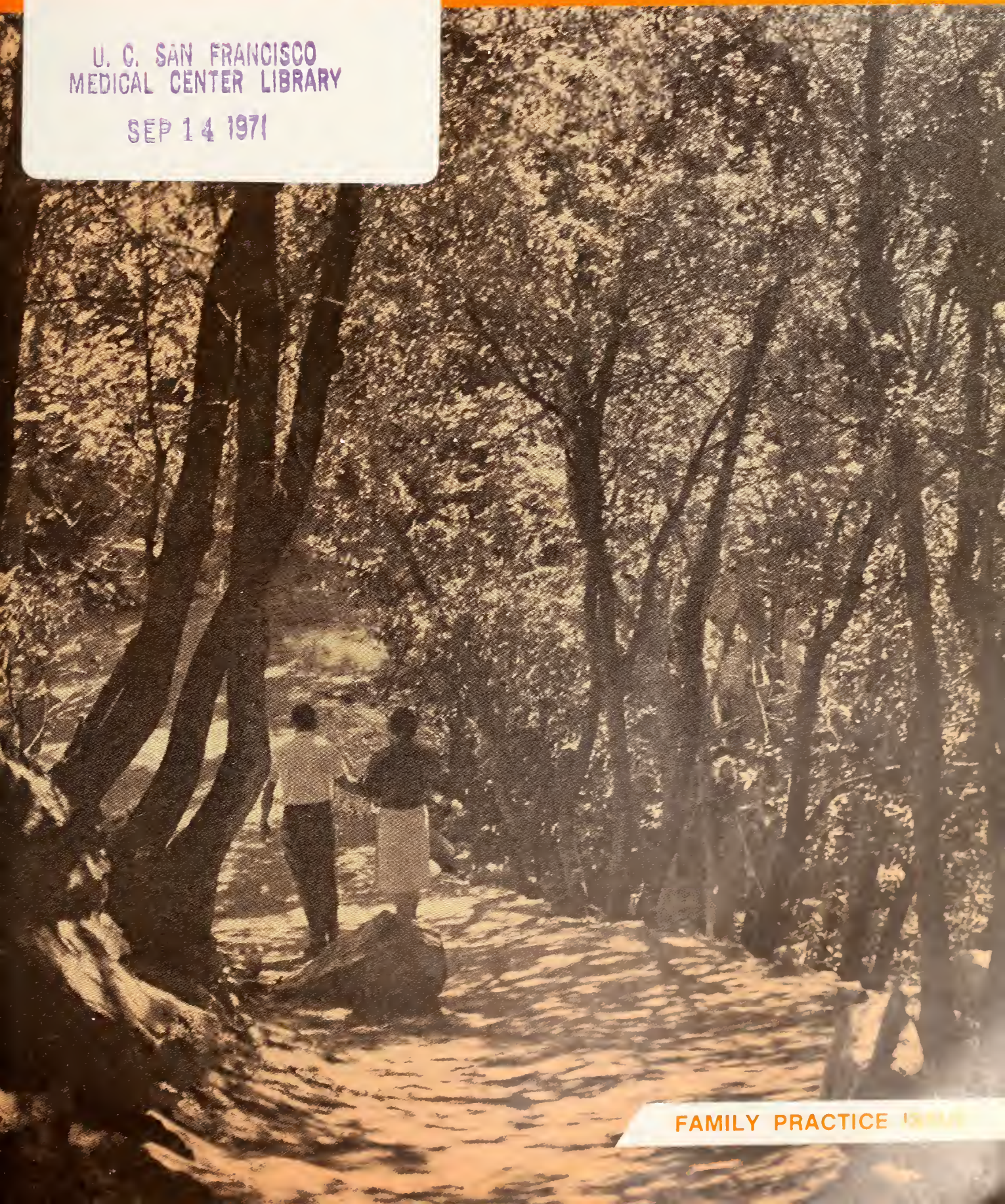
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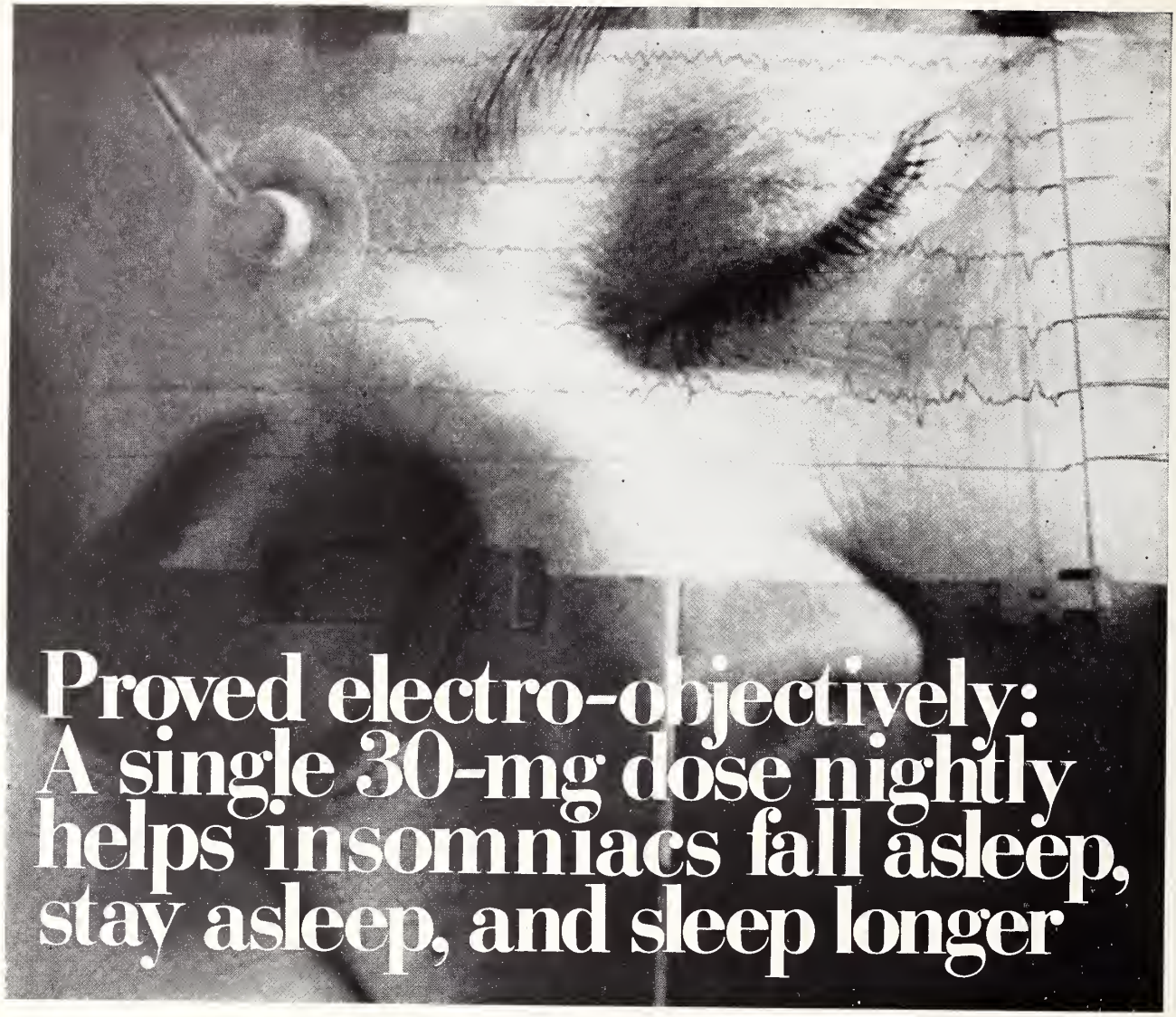
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FAMILY PRACTICE ISSUE



Proved electro-objectively: A single 30-mg dose nightly helps insomniacs fall asleep, stay asleep, and sleep longer

Controlled studies of 23 insomniac and 13 normal subjects treated with Dalmane (flurazepam HCl) in five sleep laboratories generated over 4000 hours of electroencephalographic, electro-oculographic and electromyographic tracings. These studies revealed that Dalmane 30 mg nightly usually induces sleep in 22 minutes and provides seven to eight hours of sleep.[1,2,3]

Moreover, Dalmane 30 mg was found to be useful in all common types of insomnia in which it was studied. Of drugs studied in a sleep laboratory,' Dalmane 30 mg was the only one that consistently reduced sleep induction time and maintained sleep nightly for 14 consecutive nights of use.

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Fifty-three controlled studies using a paired-night, double-blind crossover design have evaluated Dalmane clinically. In the majority of these, Dalmane (flurazepam HCl) significantly reduced sleep induction time and increased sleep duration. Dalmane and a placebo were alternated on successive nights in 2010 insomniacs, 1706 of whom were studied for a single night-pair, and the remainder for as many as fifteen paired-nights. A patient preference for Dalmane was apparent in the paired-night studies.

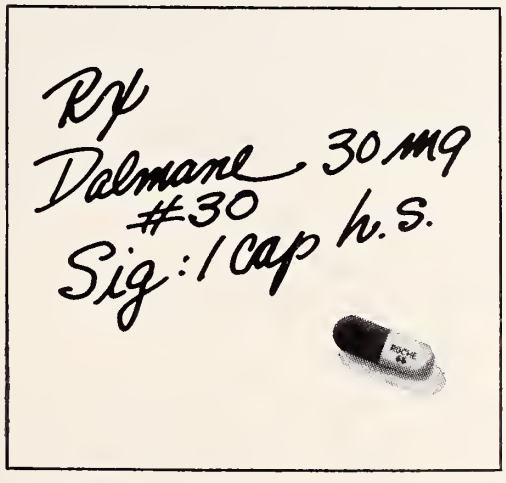
Dalmane was also preferred to certain hypnotics in two separate preference studies. In each of two double-blind studies, Dalmane 30 mg retained effectiveness for the total period of seven consecutive treatment nights, according to subjective/objective evaluations.

In summary, Dalmane is useful in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening. It can be used effectively in patients with recurring insomnia or poor sleeping habits, and in acute or chronic medical situations requiring restful sleep.

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References: 1. Kales, A., *et al.:* "Effectiveness of Sleep Medications: All-Night EEG Studies of Hypnotic Drugs," in Proc. 7th Internat. Cong. Electroencephal. and Clin. Neurophysiol., San Diego, Calif., Sept. 13-19, 1969. **2.** Kales, A., *et al.:* "Psychophysiological and Biochemical Changes Following Use and Withdrawal of Hypnotics," in Kales, A. (ed): *Sleep: Physiology and Pathology,* Phila., Lippincott, 1969, p. 331. **3.** Data on file, Medical Department, Hoffmann-La Roche Inc.



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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.,* excitement, stimulation and hyperactivity, have also been reported in rare instances.

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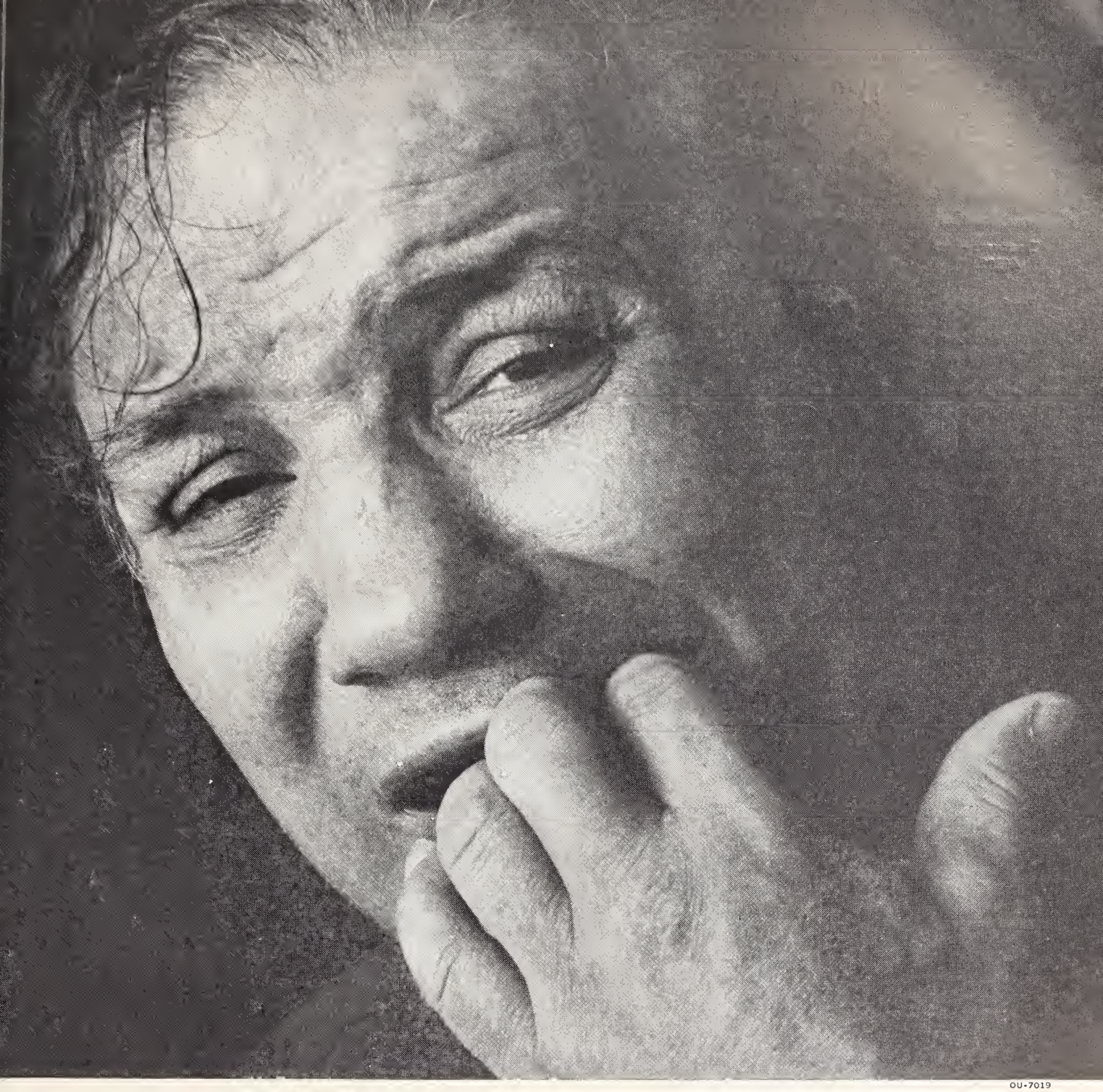
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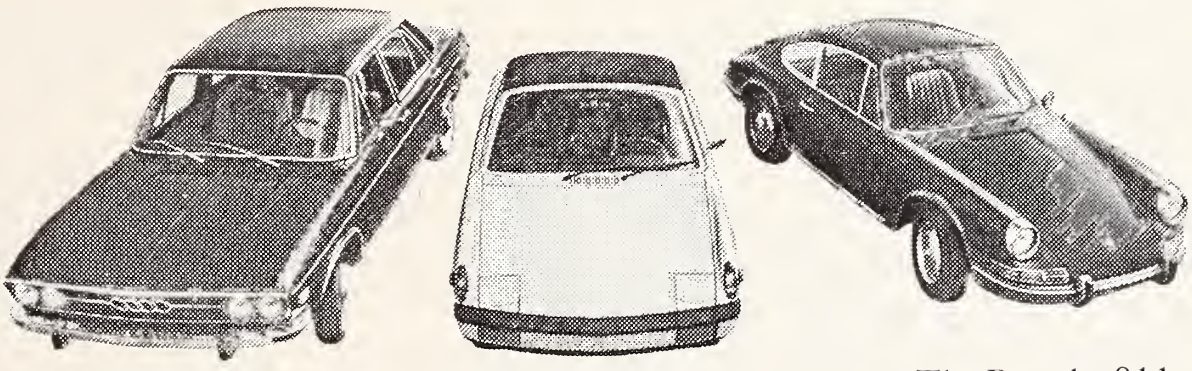
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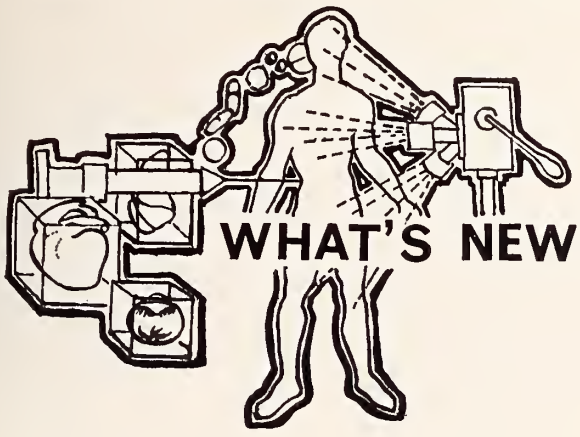
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Wang Medical Systems has a new multipurpose data analysis system for medical use. It will process medical histories, analyze clinical laboratory tests and will perform other calculations such as determining cobalt treatment dosages. It is simple enough for operation by clerical personnel. The system is expensive (less than $10,000), but comes with medical history questionnaires and 16 programs for laboratory use. In a health center or hospital which will utilize its full capacity it will perform work at an extremely reasonable cost.

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Variety Products has a new type of back rest, called Porta-Rest, which is designed to aid those with the low back syndrome. It may be used in the home, office, or in the auto. It is light enough to be carried. It furnishes additional support for the lumbar curve.

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Posey makes wrist and ankle restraints for ambulatory patients. Padded restraints are fitted so the wristlets may be secured to a nylon webbing belt and the ankle restraints are connected to an adjustable belt which will allow the patient to walk slowly. Recommended for the patient who is difficult to manage.

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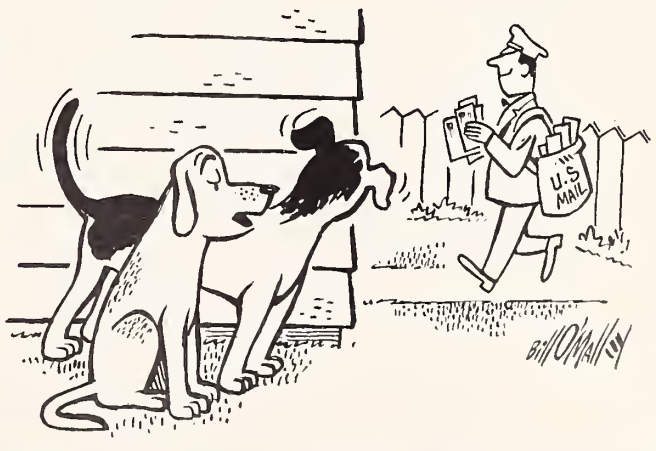


The value of early fitting

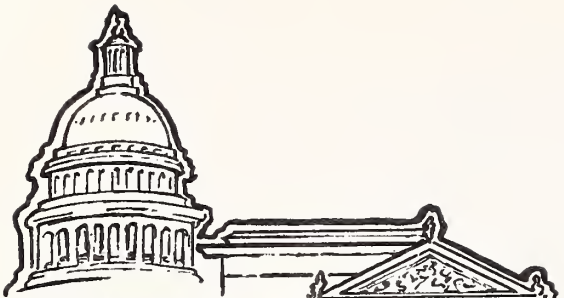
Research has proven the fitting of prostheses on children should be accomplished as early as is practicable. It has only been a few years since the child amputee was not considered ready until just before pre-school age or even later. Extensive experience demonstrates that fitting at a much earlier age produces more effective results.
If there are no complicating factors, children with arm amputations usually should be provided with a passive type of prosthesis soon after they are able to sit alone, generally at about six months of age.
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MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

THE CONGRESS has been asked by the Administration to authorize an additional expenditure of $155 million for the control of drug addiction. In his special message to the House and Senate, President Nixon said: "If we cannot destroy the drug menace in America, then it will surely destroy us."

THE ADMINISTRATION'S program would:

—Make Veteran's Administration facilities available to all former servicemen in need of drug rehabilitation regardless of the nature of their discharge and provide $14 million for this program.

—Seek $105 million from Congress to be used solely for treatment and rehabilitation of drug addicts.

—Request an additional $10 million to improve education programs on dangerous drugs.

—Request special legislation permitting the government to use information obtained by foreign police and other technical measures to make it easier to prosecute drug pushers.

—Ask for an additional $25.6 million for the Treasury Department to expand efforts against smugglers.

—Request $2 million to expedite research and development of detection equipment and techniques.

—Request $2 million for the Agriculture Department to develop herbicides that would destroy narcotics-producing plants.

—Request $1 million for assistance to other nations in training law enforcement officers.

IMPLICIT IN THE Presidential drug control proposal is the endorsement of the use of methadone in the treatment of Vietnam veterans addicted to heroin. This high level sanction of the heretofore somewhat controversial and experimental use of methadone marks a turning point in the nation's attempt to rehabilitate addicts. Observers believe the decision to make wide-scale use of methadone was influenced by official recognition of the discouraging low "cure" rate from other approaches to the problem.

NAMED BY THE PRESIDENT to head the new drug control program was Jerome H. Jaffe, M.D., a Chicago psycholopharmacologist and director of the Illinois State Drug Abuse Program. Dr. Jaffe, an advocate of the methadone treatment method, will serve as a White House consultant until the new agency is organized.

SHORTLY AFTER the announcement of the new drug control program President Nixon asked the American Medical Association's House of Dele-

gates meeting in Atlantic City to join in the nationwide war on drug abuse.

AFTER DETAILING at some length the growing social dangers of drug abuse, the President said that there was a link between the inappropriate use of drugs within the medical context and the abuse of drugs outside that context.

"CONSIDER THESE FACTS for a moment: In the last four years alone, the production and distribution of tranquilizers in our country has doubled. During 1970, 5 billion doses of tranquilizers, 3 billion doses of amphetamines and 5 billion doses of barbiturates were produced in this country. Listen to this: The estimate is that 50 percent of the amphetamines and barbiturates were diverted into illegal sales. So there is a problem in the terms of education as well as enforcement.

"TRANQUILIZERS, amphetamines and barbiturates, as you know, are known as psychotropic or mind-altering drugs. It is estimated that one-third of all Americans between the ages of 18 and 74 used a psychotropic drug of some type last year. And little wonder — for there were enough drugs of this type available last year to medicate every adult in the United States at very high dosage rates for more than 11 days.

"WE HAVE PRODUCED an environment in which people come naturally to expect that they can take a pill for every problem — that they can find satisfaction and health and happiness in a handful of tablets or a few grains of powder."

CHALLENGES ORGANIZED MEDICINE TO PROVIDE LEADERSHIP

IN ADDITION to his call to physicians to assist in the drug control program, the President in his Atlantic City address also challenged organized medicine to provide the leadership "this country craves" in all areas of health care.

"THE HEALTH OF AMERICA is in your hands, and by its health I speak not just of its physical health (but) its mental health, its moral health, its character," the President said.

IN IMMEDIATE RESPONSE to the President's challenge to American Medicine, the AMA's special communications program answered the Chief Executive's call for physician leadership in a full page message that appeared in many of the nation's principal newspapers. The message, titled "We accept, Mr. President," responded point-by-point to Mr. Nixon's request for broad physician support in all aspects of the nation's health.

PLEDGE TO ASSIST IN CURBING DRUG ABUSE

IN A RECENT letter to the Bureau of Narcotics and Dangerous Drugs the AMA has stated that it will do everything possible to assist in implementing a proposed regulation that will curb the abuse of amphetamines and methamphetamines. "Physicians throughout the nation are concerned about the alarming dimensions of the drug abuse problem," wrote Richard S. Wilbur, M.D., AMA's deputy executive vice-president. Pointing out that while the proposed regulation reclassifying amphetamines and methamphetamines

Continued

as narcotic substances such as morphine, codeine, and opium would add to the inconvenience of physicians in their practices through additional requirements concerning ordering, record-keeping and prescribing, Dr. Wilbur assured the Bureau that most physicians were in accord with the proposed regulation.

THE AMA LETTER followed quickly after the House of Delegates meeting in Atlantic City in late June adopted the following resolution:

RESOLVED, That the American Medical Association urge all physicians to limit their use of amphetamines and other stimulant drugs to specific, well-recognized medical indications, and be it further

RESOLVED, That the American Medical Association support the proposal of the Bureau of Narcotics and Dangerous Drugs to transfer Amphetamine and Methamphetamine and their Salts, Optical Isomers, and Salts of their Optical Isomers from Schedule III to Schedule II published in the May 26, 1971, Federal Register.

CONGRESSMAN Paul G. Rogers (D. - Fla.), chairman of the House Commerce Sub-committee on Public Health and Environment, has lauded the AMA for being in the forefront in the support of the Health Manpower and Nurse Training legislation. In a letter addressed to the AMA Washington office, Congressman Rogers wrote:

"THE DATA and expertise of the Association's witnesses were most helpful. The AMA's governing body wisely included medical manpower legislation as a part of the Association's legislative package. I feel this legislation is a keystone to any additional health programs that may be passed by the Congress."

FULL FUNDING REQUESTED

FULL FUNDING of a number of new and continuing health programs has been urged by American Medical Association officials appearing before a House appropriations subcommittee.

MATERNAL AND CHILD health care, communicable disease control and vaccination assistance, alcoholism prevention and treatment, and regional medical programs, as well as a number of newly proposed programs for the development of medical manpower, were endorsed with a request for full funding by Raymond T. Holden, M.D., a practicing physician in Washington and a member of the AMA Board of Trustees.

DR. HOLDEN STRESSED "the urgent need of increased financial support for the continuation of existing medical schools and for the continued development of new schools." He also asked for the subcommittee's full support for nursing education, and the development of allied health personnel to meet the manpower needs of the nation's health care delivery system.

DR. HOLDEN gave the AMA's support to the programs of prevention and control against venereal disease, rubella, measles, Rh disease, poliomyelitis, diphtheria, tetanus, and whooping cough. He noted substantial progress in the past in reducing the incidence of diseases covered by the former Vaccination Assistance Act, but added: "we are greatly concerned with reports that indicate declining levels of immunization protection against measles, poliomyelitis and diphtheria, in the United States."

THE AMA spokesman also urged the subcommittee to appropriate the full $100 million authorized by the Comprehensive Alcohol Abuse, Treatment and Rehabilitation Act.

IN TERMS OF economic loss, the unproductiveness of the alcoholic during his 30's, 40's, and 50's is augmented by the several billions of dollars industry loses annually through absenteeism and on-the-job accidents related to alcoholism and alcohol abuses.

REMINDING the subcommittee that while the 1972 fiscal authorization for Regional Medical Programs (heart, cancer, stroke and kidney disease) is $150 million, Dr. Holden said, "We do not believe the $52 million currently requested for support is sufficient to adequately meet the needs for continuation and expansion of appropriate programs under this legislation, even though some $34 million may remain available from previous appropriations." ◄

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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Volume 64 — August 1971 — Number 8

The Diagnosis and Treatment of Hyperlipemia

JACK L. KANE, M.D.

RICHARD C. POWELL, M.D.

Indianapolis*

An understanding of the hyperlipemias is important to clinicians because of the known correlation of elevated plasma lipids with arteriosclerosis.[1,2] Admittedly there are several other associated factors such as age, sex, racial and hereditary traits, hypertension, diabetes mellitus, and, probably, obesity, cigarette smoking, lack of adequate exercise and the presence of certain personality or behavioral characteristics.[3] However, the hyperlipemias are particularly relevant today because effective therapy is now available to lower plasma lipids both by dietary and drug management, and because evidence is beginning to accumulate showing that this therapy may retard the further progression of arteriosclerosis and its clinical sequelae. This evidence includes observations of the National Diet Heart Study[4] and studies reported by Leren,[5] Stamler,[6] Christakis,[7] Bierenbaum,[8] and Turpeinen.[9] The purpose of this paper is to consider both the diagnosis and the treatment of these hyperlipemic states.

Who Should Be Screened?

All "high risk" patients should be evaluated. Certainly those with clinical evidence of arteriosclerosis, including coronary heart disease, cerebrovascular or peripheral vascular disorders, should be studied, particularly younger patients with evidence of accelerated or premature disease. Those with a strong family history of vascular disease, diabetes mellitus, and/or lipid disorders should be examined. Also patients with xanthomas (yellow plaques or nodules of lipid deposited beneath the skin) or a cloudy fasting serum should be screened. Perhaps the young male executive who is constantly under tension and stress should also be considered. We, as physicians, are all aware of the typical "coronary prone" patient—he is "a mesomorphic, obese, middle-aged male with high serum cholesterol, high blood pressure, low vital capacity, and an abnormal electrocardiogram. He eats too much of too-rich foods, smokes cigarettes to excess, and is physically inactive both in occupation and in recreation. He is ambitious, aggressive, and subject to frequent deadlines and other emotional stress."[10]

Screening Tests

There are numerous tests available to measure plasma lipids. Most circulating lipids are complexed with proteins to form macromolecules called lipoproteins, and some tests are based on separation and analysis of these lipoproteins directly, rather than estimating the content of a particular lipid fraction. We feel the estimation of triglyceride and the total cholesterol levels are best for screening. Because triglyceride levels are nor-

* From the Department of Medicine, Indiana University School of Medicine, Indianapolis 46202. This work was supported in part by Heart Research Grant H-6308, National Heart Institute; Indiana Heart Association grant-in-aid; and Clinical Research Center Grant FR-00057, National Institutes of Health.

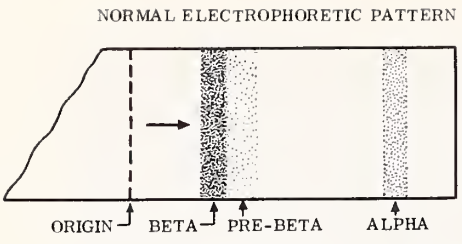


FIGURE 1

A normal electrophoretic pattern reveals lightly stained alpha (high density) lipoproteins migrating farthest from the origin and darkly stained discrete beta (low density) lipoproteins containing most of the circulating cholesterol. Traces of pre-beta (very low density) lipoproteins are occasionally noted. Increased pre-beta lipoproteins suggest carbohydrate-induced endogenous hypertriglyceridemia. Origin lipoproteins are chylomicrons and indicate fat-induced exogenous hypertriglyceridemia.

mally elevated postprandially, it is most important to obtain blood for analysis after an overnight or 12-hour fast. Furthermore, patients should be tested after several days of a regular or customary diet pattern. Carbohydrate metabolism also is evaluated routinely with postprandial blood sugars, since diabetes mellitus often disturbs lipid metabolism. When interpreting the triglyceride and cholesterol levels it is important to remember that "normal values" increase with age. We consider triglyceride levels over 160 mg per 100 ml and total cholesterols over 240 mg per 100 ml excessive in young adults. Triglycerides over 190 mg per 100 ml and cholesterols above 280 mg per 100 ml are probably abnormal in older age groups. Variations in laboratory methodology must be considered when evaluating test results. Furthermore, there is some physiologic variation from day to day. Thus, in borderline cases it is best to repeat the tests before making a definitive diagnosis.

If either the triglyceride or cholesterol level is elevated, we characterize the hyperlipemia further by obtaining fasting plasma for lipoprotein electrophoresis. This test is relatively simple, convenient and economical.[11] Figure 1 depicts diagrammatically a normal pattern and the four major areas or potential bands to be considered when interpreting lipoprotein electrophoretic patterns. This technique is particularly useful in separating fat-induced, exogenous chylomicronemia from carbohydrate-induced, endogenous hypertriglyceridemia (Figure 2). Visual inspection of plasma is often quite helpful. Triglyceride levels above 400 or 500 mg per 100 ml are suggested if the plasma is cloudy or lactescent. With practice one can approximate triglyceride levels simply by estimating the degree of turbidity. Chylomicrons, but not endogenous very low density lipoproteins, often float to the top as a discrete creamy layer if plasma is allowed to stand overnight in the refrigerator.

It is currently possible to classify the hyperlipoproteinemias into five types based primarily on lipoprotein patterns.[11,12] These groups can also be differentiated by triglyceride and cholesterol analyses and the characteristic clinical features (Table I). This classification has proved helpful in planning treatment; however, there are limitations. Typing by number does not offer a description of the underlying pathophysiology. The classification is becoming more complex as subgroups are identified. Furthermore, lipoprotein typing does not differentiate the primary, familial hyperlipoproteinemias from those secondary to diseases such as diabetes mellitus, hypothyroidism, pancreatitis, alcoholism, the hypoproteinemias, obstructive liver disease, and glycogen storage disease. This differential is most important since therapy for these secondary hyperlipemias should be directed toward the underlying primary disease.

Hypercholesterolemia (Type II)

Hypercholesterolemia is one of the commonly encountered hyperlipemias and it is strongly associated with clinical arteriosclerosis. This type is characterized by an elevated total cholesterol, normal or nearly normal triglycerides and therefore a clear or non-lactescent plasma, and a discrete increase in the beta lipoprotein band on electrophoresis (Figure 1). Glucose tolerance is usually normal. If familial, this disease may present in childhood, and a family history often reveals premature arteriosclerosis and/or hypercholesterolemia. Physical examination may reveal xanthelasma, tuberous xanthomas on extensor surfaces and/or tendon xanthomas appearing on the knuckles or heels. Tendon xanthomas are less common than xanthelasma or tuberous lesions but more diagnostic of this disease. Hypothyroidism, diabetes mellitus, hypoproteinemia, and obstructive liver disease must be excluded as primary disorders.

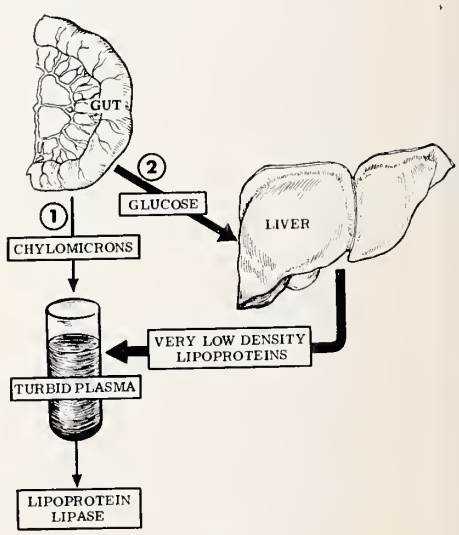


FIGURE 2

HYPERTRIGLYCERIDEMIA Mechanisms. Pathway (1) depicts fat-induced exogenous hyperchylomicronemia. A defect in clearing or removing triglyceride-rich chylomicrons from blood (deficient lipoprotein lipase activity) results in turbid plasma. Dietary fats aggravate and fat free diets improve this hypertriglyceridemia. Pathway (2) follows a carbohydrate-induced endogenous hypertriglyceridemia, a result of increased hepatic lipogenesis (conversion of carbohydrate into fat) and release of very low density lipoproteins. Turbid plasma results from overproduction rather than impaired clearing. Dietary carbohydrates aggravate and low carbohydrate diets improve this hypertriglyceridemia. A less common form of endogenous hypertriglyceridemia may result from excessive fatty acid mobilization from adipose tissue to the liver with increased hepatic production of very low density lipoproteins.

Therapeutic considerations for familial hypercholesterolemia include diet and drugs. We prefer to start with diet, and if this does not achieve satisfactory control we add one or more drugs to the program. The principles of dietary management include: (a) total calories designed to achieve an ideal weight, (b) substitution of polyunsaturated oils for saturated fats, and (c) limited intake of cholesterol. Application of these dietary principles is considered in the accompanying paper (Abel and Powell: An Approach to the Dietary Management of Hyperlipemia).

Several drugs are currently available (Table II), and others undoubtedly will soon be marketed. We pres-

TABLE I

CLASSIFICATION OF THE HYPERLIPOPROTEINEMIAS

Type	Cholesterol (C) Triglyceride (T) Content	Lipoprotein Electrophoresis	Clinical Features	Therapy
I. Fat-induced Exogenous Chylomicronemia	C+ T++++	Origin	Rare Onset—childhood Abdominal pain Eruptive xanthomas Hepatosplenomegaly	Low fat diet[11,12]
II. Hypercholesterolemia	C++++ T+	Beta	Common Onset—all ages Increased arteriosclerosis Xanthelasma, tuberous and tendon xanthomas	Substitution of polyunsaturated for saturated fat Low cholesterol diet Cholestyramine[12-14]
III. Hypercholesterolemia and Carbohydrate-induced Hypertriglyceridemia	C+++ T+++	Beta & Pre-beta	Onset—adults Increased arteriosclerosis Palmar and tuberous xanthomas Abnormal glucose tolerance	Weight control Low carbohydrate, Low cholesterol, polyunsaturated fat substituted diet Clofibrate[12,14]
IV. Carbohydrate-induced Endogenous Hypertriglyceridemia	C+ T+++	Pre-beta	Common Onset—adults Increased arteriosclerosis Eruptive xanthomas Hepatomegaly, obesity Abnormal glucose tolerance	Weight control Low carbohydrate diet Alcohol restriction Clofibrate[12,14]
V. Mixed Hypertriglyceridemia (Carbohydrate and Fat-induced)	C+ T++++	Origin & Pre-beta	Onset—all ages Abdominal pain Hepatosplenomegaly Eruptive xanthomas Abnormal glucose tolerance	Weight control Low carbohydrate, low fat diet Progestational agents[12,14,15]

TABLE II

DRUGS USEFUL IN TREATING THE HYPERLIPOPROTEINEMIAS[12-14]

Drug	Dosage and Administration	Mechanism of Action	Comments
Cholestyramine (Questran)	4 gm packets 1 packet 3 times daily before meals	Anion exchange resin with affinity for intestinal bile acids, thus increasing fecal excretion of these compounds	Hypercholesterolemia (Type II) Limited patient acceptance Gastrointestinal side effects
Clofibrate (Atromid-S)	500 mg capsules 1 capsule 4 times daily	Triglyceride lowering mechanism unknown	Carbohydrate-induced hypertriglyceridemia (Types III & IV) Well tolerated
Nicotinic Acid (Nicalex)	500 mg capsules 2 to 4 tablets 3 times daily with meals	Cholesterol and triglyceride lowering mechanisms unknown	Useful in both hypercholesterolemic and hypertriglyceridemic states Limited patient acceptance Side effects include pruritis, flushing, gastrointestinal irritation, and mild hepatic dysfunction
D-Thyroxine (Choloxin)	2 and 4 mg tablets 4 to 8 mg daily	Increases cholesterol catabolism and excretion	Useful in hypercholesterolemic states Avoid in patients with known organic heart disease because of potential increase in metabolic rate
Sitosterol (Cytellin)	Suspension 1 or 2 tablespoons 3 times daily before meals	A plant sterol that interferes with cholesterol absorption	Useful in hypercholesterolemic states A mildly effective agent Few side effects

ently favor cholestyramine for patients with a significant hypercholesterolemia if not troubled by side effects. Unfortunately, cholesterol and beta lipoprotein levels are more resistant to therapy in familial hypercholesterolemia than in other hyperlipemic states. Fifteen to 25% reductions are usual with present diet and drug therapy.[13,14] We check cholesterol levels every four to six weeks after starting any new therapeutic program and do not feel justified in continuing unless there is a definite sustained hypocholesterolemic effect after several months. Xanthomas may regress and symptoms such as intermittent claudication or angina occasionally are improved by therapy.

Carbohydrate-induced Hypertriglyceridemia (Type IV)

Carbohydrate-induced hypertriglyceridemia is also commonly encountered and associated with clinical arteriosclerosis. It is characterized by elevated triglyceride levels and lactescent plasma that does not form a floating top layer unless extremely turbid. The cholesterol may be somewhat increased if triglyceride levels are strikingly elevated. Lipoprotein electrophoresis reveals an increased pre-beta band that sometimes shows trailing toward the origin (Figure 1). Glucose intolerance is common and uric acid levels may be increased. The onset usually becomes manifest in adult life even when familial. Physical examination usually reveals obesity, often hepatomegaly and sometimes eruptive xanthomas. Primary disorders such as diabetes mellitus, pancreatitis, alcoholism, glycogen storage disease, and hypoproteinemia must be excluded.

Therapy for endogenous carbohydrate-induced hypertriglyceridemia is generally more satisfactory than for other types of hyperlipemia. We again begin with dietary considerations: (a) total calories designed to achieve an ideal weight, (b) low carbohydrate diet with emphasis on a reduction of table sugar (sucrose), and (c) reduced alcohol consumption since this hypertriglyceridemia is aggravated by alcohol. Weight reduction in obese patients is associated with dramatic improvement in triglycerides and often in clinical symptoms. Thus, dietary management is most effective in cooperative patients. However, drugs are also helpful and should be considered when diet alone is not successful (Table II). Clofibrate is currently the drug of choice.

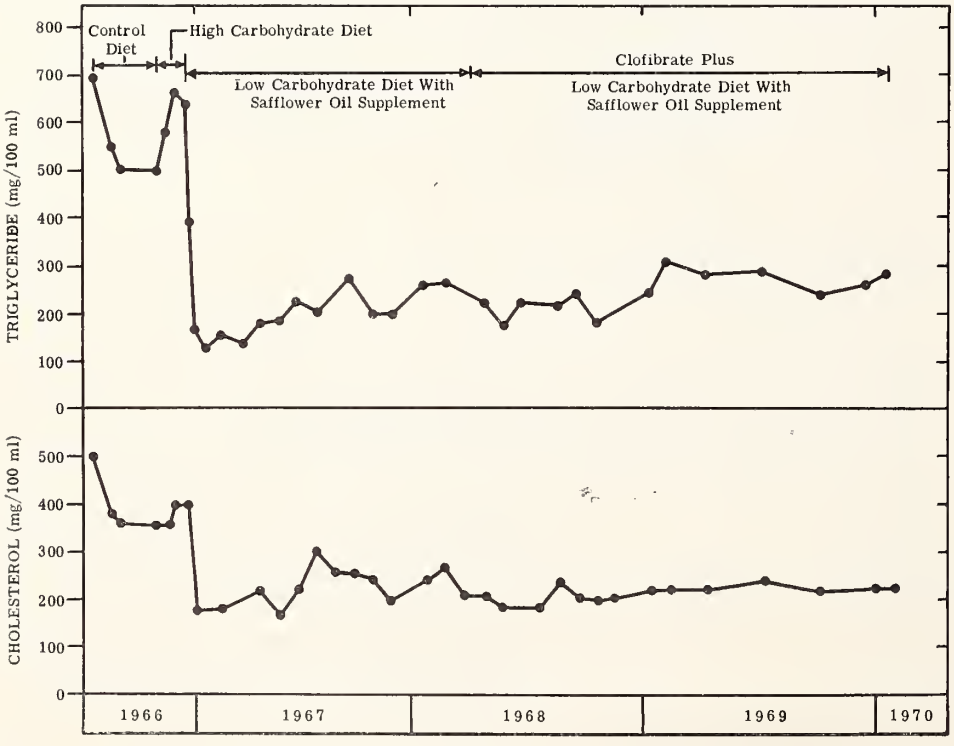


FIGURE 3

RESULTS of Treatment in Type III Hyperlipoproteinemia. All diets are similar in total calories and protein content. Weight has remained constant throughout treatment. The control diet reduced both triglyceride and cholesterol levels slightly from ad lib feedings. The high carbohydrate diet aggravated and the low carbohydrate diet reduced to normal, both lipid parameters. Because of a slight increase in both triglyceride and cholesterol levels without weight gain, Clofibrate was added in 1968.

A Case Report

V. H., a 48-year-old Caucasian, married, machine operator, first presented in 1966 with a history of intermittent claudication. He was unable to walk one block without suffering from severe cramping leg pains promptly relieved by rest. Both legs were involved. Family history uncovered several relatives with premature myocardial infarctions and cerebrovascular accidents. Physical examination revealed normal weight and vital signs. Peripheral pulses were absent below the femorals and both feet were cool. No other cardiovascular abnormalities were noted. Several yellow subcutaneous nodules were found over both elbows. Fasting triglycerides ranged between 300 and 700 mg per 100 ml, and total cholesterols between 300 and 400 mg per 100 ml while on a regular diet. Two-hour postprandial blood sugars were normal. Lipoprotein electrophoresis demonstrated an increase in beta and pre-beta lipoproteins suggesting a Type III or mixed hyperlipoproteinemia (Table I). Secondary hyperlipemic states were excluded, and a sister with abnormal lipids was found. Thus, a familial primary hyperlipemic state involving both cholesterol and carbohydrate-induced hypertriglyceridemia was established. A 2000-calorie low-carbohydrate, poly-

unsaturated oil supplemented diet was started. Details of the diet are discussed in the accompanying paper. The response of circulating lipids is shown in Figure 3. After 14 months on diet therapy alone, Clofibrate was added. Weight has remained stable throughout the study. This treatment program has maintained plasma lipids at near normal levels for more than four years. Furthermore, there has been a definite improvement in exercise tolerance, in that walking more than one-half mile at the same rate is possible before claudication symptoms are induced.

Summary

Arteriosclerosis is a common and serious clinical problem. Although pathogenetic mechanisms are not yet understood, a number of risk factors have been established, including certain hyperlipemic states. These hyperlipemias may be diagnosed by measuring fasting plasma triglyceride and total cholesterol levels. Once an abnormality is established, lipoprotein electrophoresis is helpful for classification and planning a treatment program. Principles of dietary management and drug selection are considered for the commonly encountered hyperlipemias and a case report demonstrates the use of these principles. An accompanying article considers the details of dietary management.

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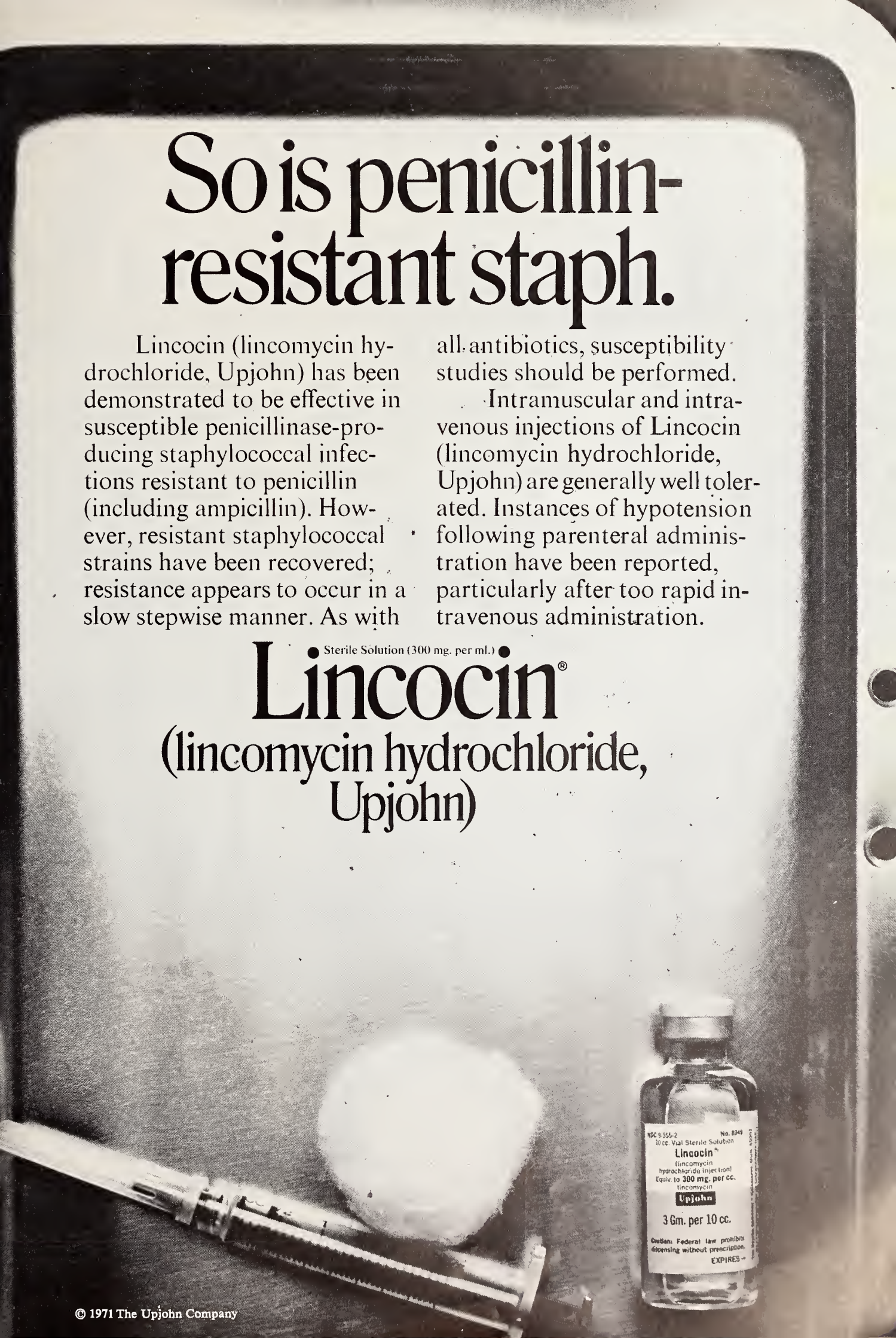
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CONTRAINDICATIONS: History of prior hypersensitivity to Lincocin (lincomycin hydrochloride). Not indicated in the treatment of viral or minor bacterial infections.

WARNINGS: Cases of severe and persistent diarrhea have been reported and at times drug discontinuance has been necessary. This diarrhea has been occasionally associated with blood and mucus and at times has resulted in acute colitis. This reaction usually has been associated with oral therapy, but occasionally has been reported following parenteral therapy. Although cross sensitivity to other antibiotics has not been demonstrated, make careful inquiry concerning previous allergies or sensitivities to drugs. Safety for use in pregnancy has not been established and Lincocin is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

PRECAUTIONS: Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of β-hemolytic streptococci infection for ten days to diminish likelihood of rheumatic fever or glomerulonephritis.

ADVERSE REACTIONS: *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatment. *Skin and mucous membranes*—Skin rashes, urticaria, vaginitis, and rare instances of exfoliative and vesiculobullous dermatitis have been reported. *Liver*—Although no direct relationship to liver dysfunction is established, jaundice and abnormal liver function tests (particularly serum transaminase) have been observed in a few instances.



Cardiovascular—Instances of hypotension following parenteral administration have been reported, particularly after too rapid I.V. administration. Rare instances of cardiopulmonary arrest have been reported after too rapid I.V. administration. If 4.0 grams or more administered I.V., dilute in 500 ml. of fluid and administer no faster than 100 ml. per hour. *Local reactions*—Excellent local tolerance demonstrated to intramuscularly administered Lincocin. Reports of pain following injection have been infrequent. Intravenous administration of Lincocin in 250 to 500 ml. of 5% glucose in distilled water or normal saline has produced no local irritation or phlebitis.

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An Approach to the Dietary Management of Hyperlipemia

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THE principles of dietary management differ depending on the type of hyperlipemia to be treated. Recommendations for some patients focus on weight reduction and the amount of dietary carbohydrate. For others, substitution of polyunsaturated oils for dietary fat and low cholesterol diets are suggested. The purpose of this paper is to consider an approach which the authors have found successful in translating these principles of dietary management into a useful and flexible regimen tailor-made for each patient. First, the diagnosis and type of hyperlipemia is established as discussed in the preceding paper. Next, a dietary prescription is calculated based on the type of hyperlipemia and patient needs. Then, the prescription is translated into a food exchange system modified slightly from the one used by many diabetics. Finally, sample menus and meal plans are prepared.

The Dietary Prescription

The dietary prescription for each patient is individualized and suggests a recommended daily total caloric intake and gram amounts for each of the macronutrients protein, carbohydrate, and fat. In addition, the type of dietary fat, cholesterol content, distribution of calories and alcohol intake are considered.

Total calories are calculated to achieve an ideal weight. For most adults, the daily total caloric intake will range from 20 to 35 calories per kg of ideal body weight, or between 800 and 2500 calories, depending in part on physical activity.[1]

It is particularly important to achieve weight reduction in patients with carbohydrate-induced hypertriglyceridemia but certainly desirable in all overweight patients. Calorie levels should be readjusted during treatment if desired results are not achieved.

Protein can be used liberally. Most diets contain from 1 to 1½ g protein per kg ideal body weight, or from 15 to 20% of total calories. Therefore, most diets contain from 50 to 100 g of protein daily.

Carbohydrate can be used in normal proportions when prescribing diets for patients with hypercholesterolemia (Type II hyperlipoproteinemia). Thus carbohydrate may equal 40 to 50% of total calories or contain at least twice as many grams of carbohydrate as protein. However, carbohydrate should be restricted to approximately 30% of total calories for patients with carbohydrate-induced hypertriglyceridemia (Types III, IV, and V hyperlipoproteinemia). This usually means between 100 and 160 g of carbohydrate. The type of carbohydrate also should be considered in carbohydrate-sensitive patients with emphasis on restricting sucrose or table sugar.

Fat usually is not reduced in total amount, and therefore will constitute 40 to 45% of total calories. Fat in grams should approximate or slightly exceed protein in the diet. When treating hypercholesterolemia (Types II and III), the kind of fat is important. Polyunsaturated oils should be substituted for saturated fats. This means reducing the intake of foods high in fat and substituting polyunsaturated oils or margarines containing polyunsaturates. Therefore, most dietary prescriptions will contain 20 to 40 g of fat from food and 40 to 90 g from oils and margarines. These modifications in dietary fat achieve the high polyunsaturated to saturated fatty acid ratio discussed by some authors.[2] Cholesterol in the diet also should be reduced by instructing patients to avoid cholesterol-rich foods (See Appendix B). Emphasis on substituting polyunsaturated oils and reducing dietary cholesterol is not necessary for patients with carbohydrate-induced hypertriglyceridemia (Type IV).

Calories are usually distributed into three equal meals with a small bedtime snack, if desired. Omitting breakfast and lunch in order to enjoy a large "gourmet" meal is not condoned. Patients with carbohy-

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drate-induced hypertriglyceridemia (Types III and IV) must also be instructed to restrict alcohol intake because triglyceride levels are often markedly increased following even modest consumption.

Food Exchange Lists

To translate the dietary prescription into a form useful to patients, standard diabetic food exchange lists[3] are used with slight modifications to control dietary fat (Table I). The milk exchange list contains only skim milk products. The meat list emphasizes lean meats. The fat category lists only oils and margarines containing at least 40% of the fat as polyunsaturates. Complete food exchange lists are included in Appendix A.

The dietary prescription is translated first into the total number of exchanges allowed daily in each food category. This is easily accomplished by considering the food lists one through six in order (Table I). Determine the skim milk, vegetable and fruit exchanges desired, and the grams of carbohydrate and protein needed for these servings. This will vary somewhat depending on patient likes and dislikes; however, a good starting point is two exchanges of skim milk, one or two exchanges of group B vegetables, and three fruit exchanges. The remaining carbohydrate is calculated for bread exchanges, the remaining protein for meat exchanges and the remaining fat for fat exchanges. This list of total exchanges is then divided into sample menus and meal plans.

Table II

Total Food Exchanges for the Day

List	Food Category	Number of Exchanges	Grams Carbohydrate	Grams Protein	Grams Fat
1	Skim Milk	2	24	16	—
2a	Vegetables A	as desired	—	—	—
2b	Vegetables B	2	14	4	—
3	Fruits	4	40	—	—
4	Breads	5	75	10	—
5	Meats	8	—	64	24
6	Fats and Oils	18	—	—	90
		Total	153	94	114

A Case Report

In the preceding paper a patient was discussed with arteriosclerosis obliterans and Type III hyperlipoproteinemia (mixed hypercholesterolemia and carbohydrate-induced hypertriglyceridemia). He was symptomatically helped, and his lipids were markedly improved first by diet therapy alone and later by diet and drugs. He was a 48-year-old machine operator. He stood 65 inches tall and weighed 135 pounds or 61 kg. Thus he was already at his ideal body weight. On the basis of this information, a diet prescription was calculated containing 2000 total calories - 160 g carbohydrate, 90 g protein, and 110 g fat. Note that total calories were set between 30 and 35 calories per kg ideal weight. Protein was figured at 1½ g per kg and carbohydrate was restricted to 30% total calories. Remaining calories were fat with 20 g from food and 90 g as polyunsaturated oils. A list of total food exchanges was next prepared (Table II). Milk, vegetable, and fruit exchanges were first determined from the patient's food habits and desires. Remaining carbohydrate (160 minus 78 = 82 g) was calculated for bread exchanges, remaining protein (60 g) for meat exchanges, and remaining fat (86 g) for fat exchanges. In this case three of the eighteen fat exchanges were margarine, and the remaining were safflower oil. Finally sample menus were prepared from this list by dividing the exchanges into three meals of approximately equal caloric value. A list of cholesterol-rich foods to avoid was also provided. This patient continues to follow his dietary treatment after more than four years and the results of therapy have been quite satisfying. He has found the diet to be palatable, and to contain a sufficient variety of foods to avoid monotony.

Table I

Composition of Fat Controlled Food Exchange Lists

		Exchanges or Equivalents		Nutritive Values per Exchange			
List	Food Category	Measures	Grams	Grams Carbohydrate	Grams Protein	Grams Fat	Calories
1	Skim Milk	1 cup	240	12	8	—	80
2a	Vegetables A	as desired	——	—	—	—	—
2b	Vegetables B	½ cup	100	7	2	—	36
3	Fruits	varies	——	10	—	—	40
4	Breads	varies	——	15	2	—	68
5	Meats	1 ounce	30	—	8	3	59
6	Fats and Oils	1 teaspoon	5	—	—	5	45

Comments

The authors feel this approach to dietary management is practical and achieves the desired results. Patients with a variety of backgrounds and interests have been instructed successfully not only in dietary principles but also in meal planning and food preparation. This approach to dietary treatment offers several advantages: (a) Diets are individualized according to the type of hyperlipemia and patient needs. (b) Diets are flexible and can incorporate

many patient food preferences. (c) Food exchange lists offer variety in meal planning thereby minimizing excessive repetition of certain foods. (d) A similar approach has been used successfully for many years in managing diabetics. Thus the system is familiar to many physicians, dietitians, and patients. Patients do need proper motivation to follow this or any other diet program. Many in our experience are quite willing to modify their dietary habits even though present evidence that this treatment slows the progression of arteriosclerosis is only suggestive. Since male patients often do not prepare their own food, it is important to counsel wives as well as patients. Neither this approach to dietary management nor any other of which we are aware can be learned in one sitting. Patients are encouraged to gradually learn principles of dietary treatment, try the food exchange system, experiment with food preparation, and then return for further counseling. Questions and discussions are often more productive during follow-up sessions. Furthermore, patient acceptance increases as knowledge and experience increases.

The dietary prescription and initial translation to food exchange lists is only a starting point. Frequently, needed changes will become apparent after several weeks, either to achieve desired results or to increase patient acceptance. There are some problems encountered repeatedly. (1) The "two eggs for breakfast" patient with hypercholesterolemia will find it necessary to substitute other foods for breakfast (See Appendix B). (2) Some patients find skim milk difficult to consume on a regular basis, particularly on cereal, and the restricted use of two percent milk may be a necessary compromise (the fat content must be calculated, however). (3) Weight reduction for some patients with carbohydrate-induced hypertriglyceridemia is difficult, but must take priority over other aspects of dietary management. Unfortunately, we know of no magical formulas or short cuts to this aspect of treatment. (4) The man on the road who eats in restaurants can be a problem; however, it is usually possible to select a satisfactory meal: clear soup, tomato juice or fruit cup for the first course; baked or broiled fish, chicken, turkey or a lean steak without gravy for the main course; baked potatoes or other vegetables without butter and a tossed salad with vinegar and oil dressing for side dishes; and fruit, sherbet, or gelatin for dessert.

In order to substitute polyunsaturated fatty acids for saturated fat in the diet, we prescribe a low fat diet and then replace the fat calories with vegetable oils and special margarines containing at least 40% of their fat content as linoleic acid (the major polyunsaturated fatty acid found in food). Corn oil, cottonseed oil, safflower oil, and soybean oil all qualify. However, because the content of linoleic acid is slightly higher, safflower oil is currently recommended to our patients. The oil can be used in salad dressings, in reconstituting skim milk, and in cooking. Several suggestions are offered in Appendix A with the fat exchanges. Patients occasionally complain of abdominal bloating and gas; however, these symptoms usually are transient. The palatability of the diet is often increased by substituting one of the soft spread margarines high in polyunsaturates for some of the safflower oil.[5] A margarine in which 40% of the fat content is linoleic acid should be selected.

The role of fat controlled diets is not yet finally established. Some suggest modifying the diet for all Americans to retard the development of arteriosclerosis. Others feel sufficient evidence is not available to warrant such drastic changes. The authors feel dietary treatment for high risk hyperlipemic patients should be offered now, but we feel it will be most important to follow closely future developments in this field and to modify treatment as new information warrants changes.

The question of Vitamin E supplementation should be considered when prescribing polyunsaturated oil supplemented diets. Tocopherol (Vitamin E) is an antioxidant that helps preserve unsaturated fatty acids that are easily oxidizable. Thus an increased need for Vitamin E might be anticipated. Although present information suggests vegetable oils contain enough of the vitamin, future studies should be examined carefully for new evidence. The food industry will undoubtedly play an important role in future dietary management. Powdered egg products with a reduced cholesterol content and skim milk reconstituted with polyunsaturated oils are available in some areas. Low fat and polyunsaturated oil supplemented cheeses can be found in some stores. Synthetic hamburger and sausage-like products made from vegetable protein and polyunsaturated oils are being tested. Cattle fed special diets to increase carcass polyunsaturated fatty acids are being evaluated. Thus, many new food products that can be used in fat controlled diets should be available soon. This should increase patient acceptance of dietary treatment because of the greater food variety and convenience.

Summary

An approach to the dietary management of hyperlipemia is presented that the authors have found to be practical and successful. First, the diagnosis and type of hyperlipemia is established. This is discusssed in the preceding paper. Second, a dietary prescription is prepared that is tailormade for each patient based on the type of hyperlipemia and his particular needs. Next, this prescription

is translated into a food exchange list system similar to the one used by many diabetics. Finally, sample menus and meals are prepared. Because this plan is individualized and flexible, the authors feel patient acceptance can be maintained over many years. A case report is presented that demonstrates the use of this approach and its success over a period of more than three years. Food exchange lists and cholesterol-rich foods are considered in the appendices.

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APPENDIX A

Food Exchange Lists

LIST 1 — Skim Milk Exchanges (1 serving or exchange contains 12 g carbohydrate and 8 g protein)

Skim milk	1 cup
Instant skim milk powder	⅓ cup
Skim milk powder	¼ cup
Buttermilk	1 cup

LIST 2 — Vegetable Exchanges

Group A (1 exchange = 1 cup and contains negligible calories) May be used as desired.

Asparagus	Dandelions
Beans, string, young	Kale
Broccoli	Mustard
Brussel Sprouts	Spinach
Cabbage	Turnip Greens
Cauliflower	Lettuce
Celery	Mushrooms
Chicory	Okra
Cucumbers	Pepper
Escarole	Radishes
Eggplant	Sauerkraut
Greens	Squash, summer
Beet Greens	Tomatoes
Chard, Swiss	Watercress
Collard	

Group B (1 exchange = ½ cup and contains 7 g carbohydrate and 2 g protein)

Beets	Peas, green	Squash, winter
Carrots	Pumpkin	Turnip
Onions	Rutabaga	

LIST 3 — Fruit Exchanges (1 exchange contains 10 g carbohydrate)

Apple (2 in)	1
Applesauce	½ cup
Apricots, fresh	2 medium
Apricots, dried	4 halves
Banana	½ small
Blackberries	1 cup
Blueberries	1 cup
Raspberries	1 cup
Strawberries	1 cup
Cantaloupe (6 in)	¼
Cherries	10 large
Dates	2
Figs, dried	1 small
Figs, fresh	2 large
Grapefruit	½ small
Grapefruit juice	½ cup
Grapes	12
Grape juice	¼ cup
Honeydew melon (7 in)	⅛
Mango	½ small
Orange	1 small
Orange juice	½ cup
Papaya	⅓ medium
Peach	1 medium
Pear	1 small
Pineapple	½ cup or 2 slices
Pineapple juice	⅓ cup
Plums	2 medium
Prunes, dried	2 medium
Raisins	2 Tablespoons
Tangerine	1 large
Watermelon	1 cup

LIST 4 — Bread Exchanges (1 exchange contains 15 g carbohydrate and 2 g protein)

Bread	1 slice
Biscuit, roll (2 inch) — made with safflower oil	1
Muffin (2 inch) — made with safflower oil	1
Cornbread (1½ inch cube) — made with safflower oil	1
Hamburger bun	½
Hot dog bun	½
Flour	2½ Tbsp.
Cereal, cooked	½ cup
Cereal, dry	¾ cup
Rice, spaghetti, macaroni, noodles, cooked	½ cup
Crackers	
Graham (2½ inch square)	2
Oysterettes	20 (½ c)
Soda (2½ inch square)	2
Saltines (2 inch square)	5
Round thin (1½ inch square)	6 to 8
Vegetables	
Beans and peas, dried, cooked (Lima, navy, split peas)	½ cup
Beans, lima fresh	½ cup
Beans, baked, no pork	¼ cup
Corn, sweet	⅓ cup
Corn, popped	1 cup
Parsnips	⅔ cup
Potatoes, white	
Baked	1 med.
Boiled	1 med.
Mashed	½ cup
Sweet potatoes or yams	¼ cup
Baked sweet	¼ cup
Sherbet	¼ cup
Sponge cake, plain (1½ inch cube)	1
Flavored gelatin	¼ cup

LIST 5 — Meat Exchanges (1 exchange = 1 ounce and contains 8 g protein and 3 g fat) Only lean meats are used. Visible fat is carefully trimmed from the meat.

FOODS TO INCLUDE:

Poultry — Chicken, turkey, Cornish hen, squab, without the skin

Fish — Any kind, except shellfish

Eggs — 1 egg twice a week

Veal — Any lean cut

Beef — For hamburger, use only ground round or chuck
Roasts, pot roasts, stew meats — made from sirloin tips, round, rump, chuck, or arm
Steaks — flank, round, cube, sirloin, T-bone, porterhouse, and tenderloin, occasionally rib and club
Soup meats — shank or shin
Dried chipped beef

Lamb — Lean roasts or steak, leg chops, loin rib, or shoulder

Pork — Lean loin or ham, fresh or smoked Canadian bacon; one serving per week

Cottage Cheese — Preferably uncreamed. If creamed, pour off excess cream

FOODS TO AVOID:

Duck, goose, stewing hens

Shellfish (lobster, shrimp, crab, clams); fish canned in olive oil, caviar, fish roe

More than two eggs a week
What is sold as hamburger in the store
Beef high in fat or "marbled"

Organ meat — heart, liver, kidney, sweet breads, tongue

Luncheon meats, frankfurters, canned meats such as Spam and Treet
Peanut butter (unless substituted for 1 egg)
Lamb high in fat, shoulder chop

Pork other than loin or ham; no bacon, sausage, spareribs

American or cream cheese

These are examples of one meat exchange:

1 slice meat — 2″ x 3″ x ¼″
Cottage cheese — ¼ cup
Egg — 1
Canned meat or fish — ¼ cup

These exceptions can be made when substituted for one of the allowed eggs per week:

1 egg = 2 ounces shellfish
(2 meat exchanges)

2 ounces liver
(2 meat exchanges)

Meat Tips:

1. Use fish, poultry and veal more often than other meats because of lower fat content.
2. Good grade beef is preferable to choice grade because less of the fat is marbled through the meat. Use round or chuck more often than other cuts because they are lower in fat.
3. For each 3-ounce serving of cooked meat, fish or poultry allow an extra ounce of raw meat to allow for shrinkage and waste; two extra ounces for meat with bone.
4. Use a rack when broiling, roasting or baking so the fat can drain off.
5. When making stews or other dishes where fat cooks out into the liquid, cook one day ahead of time. After the food has been refrigerated, the hardened fat can be removed easily from the top.

LIST 6 — Fat Exchanges (1 exchange = 1 teaspoon and contains 5 g fat) Only fats or oils containing 50% of fat as polyunsaturated fatty acids are used.

FOODS TO INCLUDE:

Safflower oil
Margarines with large amounts of polyunsaturated oils
Mayonnaise made with safflower oil, corn oil, soybean oil, or cotton seed oil

FOODS TO AVOID:

Butter, margarine, ordinary solid shortening, lard, salt, pork, chicken fat, coconut oil, olive oil, chocolate, bacon, and other salad dressings

Tips for using polyunsaturated oils

1. Salad dressing — One tablespoon oil plus one teaspoon vinegar is suitable on a small lettuce salad. If a sweeter dressing is desired, use one tablespoon oil, one teaspoon lemon juice, saccharin, and paprika.
2. Reconstituting skim milk — One tablespoon of oil can be added to one cup of skim milk. If mixed in a blender, the oil will not separate.
3. Cooked vegetables — Green vegetables such as broccoli, spinach, and green beans can be cooked with one or two teaspoons of oil per serving. The vegetables should be covered tightly while cooking.
4. Meats — Fish or chicken may be basted with oil while baking. Meat can be fried in polyunsaturated oils if care is taken not to overheat the oil.
5. Sauces — Oil may be used in barbecue sauces and sauces used for marinating meats.
6. Hot breads — Oil may be used in recipes for biscuits, muffins, etc.

APPENDIX B

Foods High in Cholesterol

1. Eggs
2. Shellfish—crab, lobster, shrimp, oysters, clams, and scallops
3. Organ meats—liver, sweetbreads, hearts

In order to restrict cholesterol intake to between 300-350 mg daily, the authors suggest limiting eggs to two per week. For breakfast this means substituting other foods such as cereal, fruit and allowed meats. New powdered egg products low in cholesterol are available in some areas and may be substituted occasionally for scrambled eggs. When eggs are called for in cooking, two egg whites can often be substituted for one whole egg. Two ounces of shellfish or organ meats may be substituted for one egg and still keep dietary cholesterol within reasonable limits. Other foods with significant amounts of cholesterol such as meat, cheese, cream, and butter are limited or avoided to keep saturated fat low. Low fat and polyunsaturated fat substituted cheeses are available in some stores. ◄

"It is the right of every citizen to have access to adequate medical care, but it is the responsibility of the citizen or of society to seek it. The American Medical Association will use all means at its disposal in an endeavor to make adequate medical care available to meet the needs of each person. . . ."—AMA House of Delegates, June 1971.

Therapeutic Abortion: A Psychiatric View

JAMES M. DONAHUE, M.D.

Indianapolis

THE present trend toward liberalizing state laws regulating therapeutic abortion has been much commented upon. From time to time a psychiatric opinion is sought in this area regarding a specific patient, or regarding the area of controversy in general. A case report is here presented which is in many respects fairly typical of those patients referred for psychiatric consultation concerning therapeutic abortion.

Louise is a 27 year old single white female. She was referred for consultation by her family physician whom she had recently seen. He had confirmed that she was pregnant at about eight weeks gestation. She had requested a therapeutic abortion. She had become withdrawn, depressed, and she said she couldn't get the idea of suicide off her mind. She had decided she would rather kill herself than bear an illegitimate child.

Louise had been hospitalized for psychiatric treatment four years previously. At that time she had become withdrawn and ultimately psychotic following the death of her fiance in an auto accident. She had begun drinking heavily, she became sexually promiscuous, and she gradually retreated into an autistic fantasy world.

Louise had come from a broken home. Her father was an alcoholic and he deserted the family when Louise was seven. Her mother is a chronic psychotic. She has never been hospitalized but is tolerated in the community as a harmless eccentric. The children seem to have raised themselves and the family subsisted on welfare and contributions from relatives.

Louise still feels guilty about not being able to understand her mother or to get along with her. She stayed at home long enough to finish high school, then moved out on her own. She began working at a local factory and now feels she has a good job there. She was married when she was nineteen, but couldn't get along with her husband and they divorced after two years. There were no children. Louise began dating a boyfriend later whom she felt very close to, and when he died she began to decompensate.

In the hospital Louise had received a course of electrical treatment and improved rapidly. However, she had relapsed again while convalescing at home with relatives and had attempted suicide with an overdose of medication. It had been evident that long term hospital care would be needed, and she was admitted to a regional state hospital as a voluntary patient. After several months there she was able to reintegrate emotionally, she was released, and she eventually returned to work. She had not had further psychiatric contact until her present pregnancy.

In the interim she had tried to establish a stable adjustment with varying success. At times she drank heavily, but she continued to work regularly and was able to make some friends. She had begun dating another man, but when he learned of her pregnancy he disappeared from the scene. Louise felt it was more than she could cope with, and she rapidly began to regress.

It was recommended that on psychiatric grounds Louise have a therapeutic abortion. This was performed shortly afterward. Louise was quite relieved, but continued to be very depressed and withdrawn. She was able to return to work, and once again began regular psychiatric treatment as an outpatient. The prognosis remains uncertain.

For a psychiatrist a consultation request for consideration of therapeutic abortion is infrequent, if not rare. A busy psychiatrist might see three or four such patients in a year, while he handles neurotic, psychotic and suicidal patients almost daily. Although there seems to be some feeling among the general public that questions concerning therapeutic abortion are a major psychiatric concern, they are not. Nevertheless, we recognize that public sentiment is changing on this issue, and that at times psychiatric guidelines are sought.

It is the official position of the American Psychiatric Association that abortion should be a strictly medical matter and that the decision should rest between the patient and her physician.[1] Criminal penalties should be reserved for those who perform abortions without medical qualifications. Psychiatric consultation may occasionally be helpful, particularly in clarifying problems of motivation.

A psychiatrist is dismayed to find that psychiatric reasons are very often given to justify a therapeutic abortion. He anticipates that true psychiatric indications for this procedure are unusual, and are almost entirely limited to two groups of patients.

Thus most patients referred for consultation regarding abortion fall into two categories: suicidal and psychotic. The patient may find herself with an unwanted pregnancy, whether married or not. She may become despondent and at the point of suicide, seeing therapeutic abortion as her only solution for the problem. It is obvious that her life is threatened, and therapeutic abortion may be justifiable on psychiatric grounds. Alternatively, we may be dealing with a patient who is psychotic on account of the pregnancy, and in such cases therapeutic abortion may be considered as the only hope for restoring the patient to a normal state of mind. Occasionally a patient is seen who has developed a major mental illness in connection with a previous pregnancy, and in whom therapeutic abortion is being considered to avert the possibility of another such disaster from which she might not recover.

One often hears of the dangers of a patient becoming remorseful and guilty after having a therapeutic abortion, and perhaps developing a worse state of depression than she would have had otherwise. In actual practice this seems to be a rare occurrence. A vast majority of patients are relieved and thankful that the pregnancy has been terminated. Where remorse or guilt does become a problem, it often appears that the patient has been mishandled in a hostile fashion by hospital personnel. An intern may say "now you've had your fun, and you're going to make us do all the dirty work." Or if the patient complains of abdominal pain after surgery the nurse may refuse to administer medication and say "go on and suffer, you're getting just what you deserve." Such incidents obviously may serve to initiate an unwanted response.

A psychiatrist does not consider his office to be a proper forum for the settling of moral or ethical issues involved in therapeutic abortion. If such questions arise, he prefers to have them settled by the patient and her family, perhaps in consultation with their pastor. A psychiatrist can claim no expertise in the field of morals. In entering this area his role at best is limited to helping the patient to explore her own motivation, both positive and negative, and to reach her own decision. He must be prepared to accept the decision regardless of whether or not he personally agrees. Similarly, although an individual psychiatrist may not always agree with the interpretation of the law regarding therapeutic abortion in the state where he practices, as a licensed physician he attempts always to conform his practice to the requirements of the law.

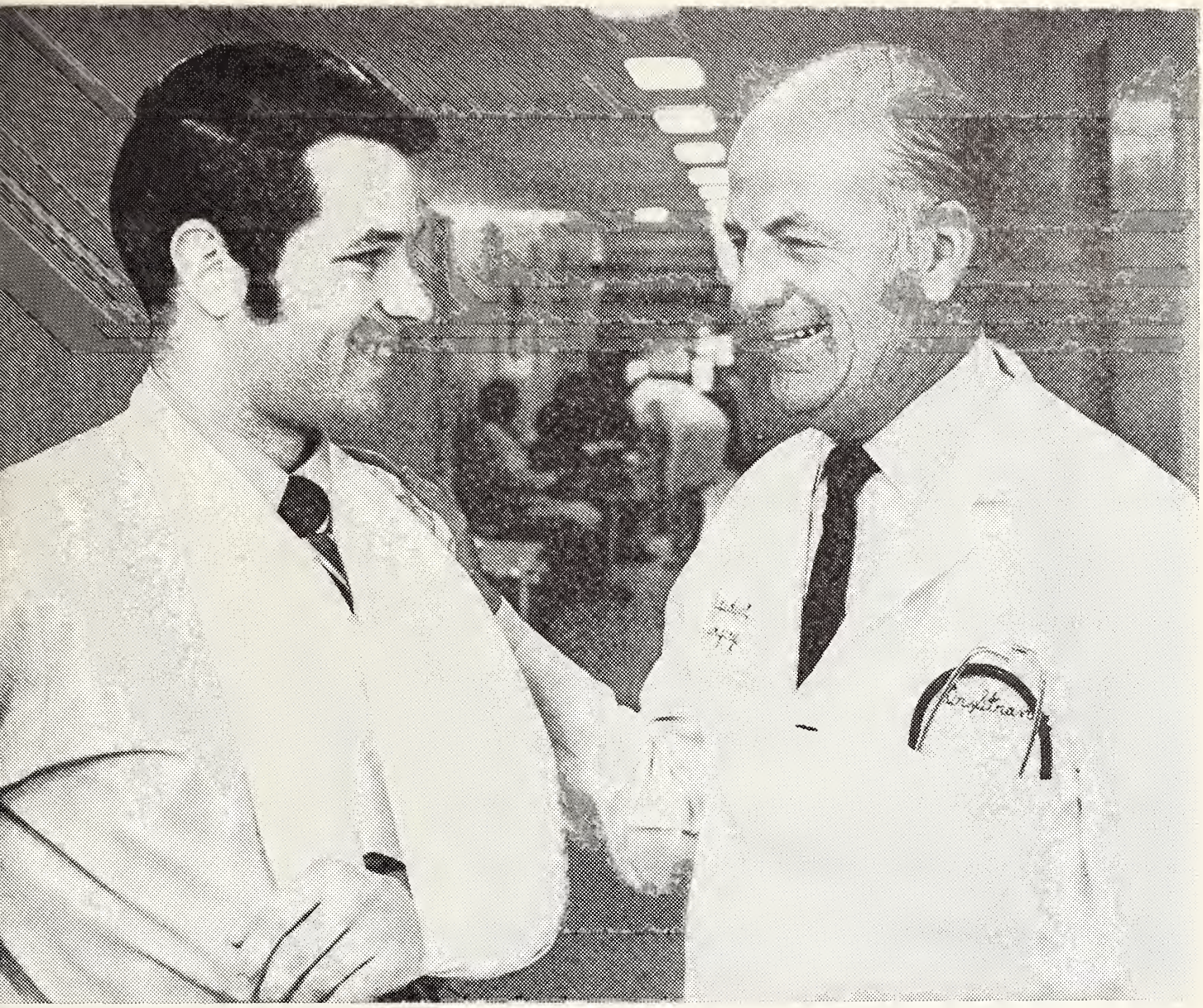
It is well known that California was one of the first states to pass a liberalized abortion law—in November 1967. There recently appeared in the phychiatric literature a review of California's experience with this law during approximately the first year it was in force, from November 1967 to September 1968.[2] During this period there were 4291 applications for therapeutic abortion; 3905 or 90% were approved. 86% of the applications were on the grounds of mental health, 9% were for rape, and 5% were for reasons of physical health. The applicants ranged in age from twelve to forty-three, with the median age being twenty three; 50% were married; 25% were under age sixteen, and 25% were over thirty; 75% were white and, during the same period, 60% of the live births in California were white. During this period there was no reduction in the number of hospital admissions for self-induced or criminal abortion. It was noted that a policy evolved of approving therapeutic abortion in any case of unwanted pregnancy or of contraceptive failure. Amelioration of anxiety and depression occurred and serious emotional problems of guilt or remorse following the abortion did not occur. The attitude of the hospital staff was sometimes noted to be a problem, particularly early in the period covered by the study.

In summary, it should be noted that therapeutic abortion is not a major psychiatric problem. It is a proper matter for medical consideration and does not belong under criminal law except if performed by persons without medical qualifications. Psychiatry can claim no expertise in discussing the moral issues involved.

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1. Position Statement on Abortion. *Am. Jnl. Psych.* 126:1554, 1970.
2. Marder, L.: Psychiatric experience with a liberalized therapeutic abortion law. *Am. Jnl. Psych.* 126:1230, 1970. ◄

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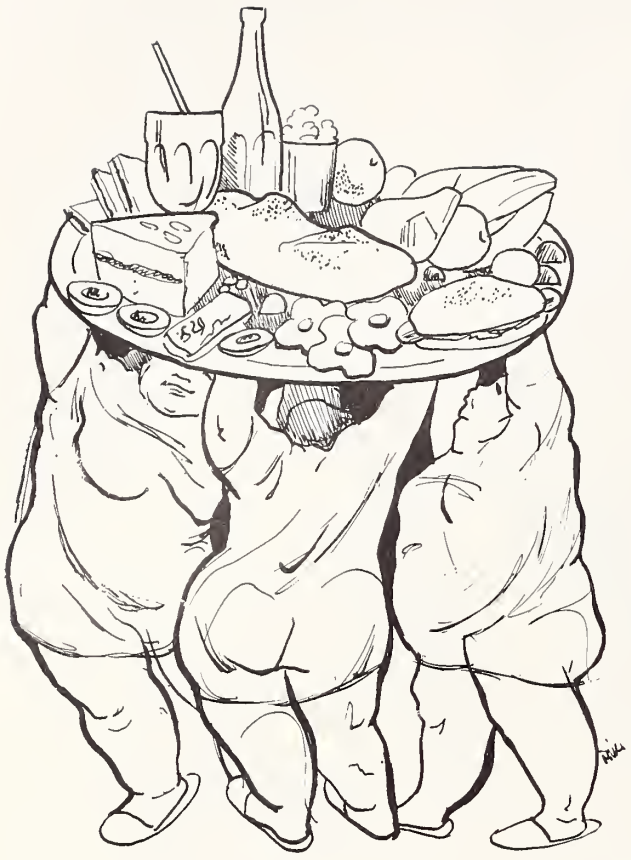
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The Case of the Gluttonously Gourmandizing Gals

ARNOLD LIEBERMAN, M.D.
New, York, N.Y.

CHARLES Dickens was only 24 years old when he published the first of his glorious novels: *The Pickwick Papers*. Illustrated by "Phiz" (Hablot Brown), it was pure rollicking fun: skewered sketches of ludicrous lunkheads drawn from all strata of English Society standing on the very threshold of the Victorian Age. Tom—the enormously obese, lethargically drowsing lad awakening only to eat—has gone into the medical literature as the very archetype of the Pickwick Syndrome. We, doctors, have learned to discourse rather solemnly on the various underlying mechanisms—the electrolyte variables, erythrocytosis, the adipocytes, the id (and such)—all finally converging through common pathways of our conscious cravings to the anatomically defined ventromedial and lateral nuclei of the hypothalamus. Sotto voce, we still confess our lack of comprehension of the actual biochemical pathways in the maze of our uncertain nervous system. Suffice to say that, in the lengthening baker's dozen of decades since 1836, Charles Dickens' exact, clinical portrayal of this metabolic aberration remains as the still unmatched paradigm.

In the mores of our contemporary society, obesity is usually the butt of jests rather than a topic for serious discussion. I'm sure you are familiar with the anecdote re the horrendously overweight matron who had come to the Mayo Clinic for advice. She was given the carefully outlined, 18-day diet specifications. After the weekend, she called her doctor. "It was hard to do but I did it: yesterday." The entire 18-day diet was consumed in a single day!

Every medical student continues to have the chore of gazing bleakly at the interminable tables listing the variables in the idealized age-height-sex averages. The searing statistics bear inexorable witness to the lurking dangers of gourmand gluttony producing deadly deposits of excess avoirdupois.

Is it any consolation to be told that the differentiation of adipose tissue was "a triumph of evolution" (Cecil-Loeb, 12th ed., p. 1164)? It appears that this was a decisive factor in permitting mammals and birds to leave the ocean (with its constant source of food) and come ashore.

The standard textbooks display surprising divergences in their approaches to the extremes of obesity. Osler's 17th edition discusses the Pickwick Syndrome as a motor neuropathy "resembling primary muscular atrophy." Harrison (5th ed., p. 914) classifies it under "disorders of the respiratory system. . . pulmonary cardiac failure. . . ." Of course, the mechanical burden can become phenomenal. Price (10th ed., p. 370) labels it unequivocally as a metabolic disorder. Williams (4th ed., p. 1085) insists on "lipopathy . . . hormonal mechanisms operating at the level of the adipocyte. . . ."

For our purposes let us make the pragmatic observation that obes-

ity results from the relative excess of caloric intake over caloric expenditure. Further, we all know that sex determines the sites for the body depots of fat. The male accumulates the fat above the waist while the female does this below the midriff. The men have the "Bier Bauch"; the ladies, the "Hottentot Bustle." Leaving aside all semi-esoteric discourses, we can accept the obvious, non-medical definition, "the dividing line between the normal and the excessive is the esthetic point at which fatness exceeds the socially acceptable norms." This is broad enough to encompass the widest variations from nation to nation. To give an instance: in Japan, Sumo wrestling is a sport followed by the widest audiences. These individuals are stuffed to repletion until they attain a ponderous 300 pounds and more; no poultry fancier can do more. Yet—in Japan—this is completely acceptable.

I believe I speak for my colleagues when I say that we see many more fat women than men. True, I recall that, quite early in my practice, I performed a Pfannenstiel operation on a man; some 50 pounds—plus were excised from his fat apron. Also, I have vivid recall of a professional fat lady in a traveling circus. At 624 pounds she had problems that were truly unique.

The obvious routine rarely merits protracted powwows. However, just this past summer, several truly bizarre instances of the Pickwick Syndrome thrust themselves upon my attention. Very early upon a Monday morning, the social worker at a municipal hospital brought to me an enormous woman; three children ages two, five and seven were trailing along. The social service worker was briskly to the point: "Mrs. B. is on welfare; she has a bust of 64″ and a waist of 55″. We need an M.D.'s signature on this special requisition for a custom made bra and girdle."

The stated age was only 32; race, Seneca Indian; three living children out of eight pregnancies; husband missing for the last couple of years. The face might have been pretty before becoming blubber-bloated. The youngsters were in scrawny contrast to their bursting-all-seams parent. The oldest was holding a vacuous thumb against a drooping lower lip. Offhand diagnoses by attending physicians may impress the recent graduates—may even go far to relax peer tensions—still, snap judgments are just that: verification must be forthcoming. A habit of many decades I find hard to shrug off. My eyes focused on the hapless boy. Was that a wrist *drop?* And: did this exposed gingival margin display the blue-black "lead-line" so characteristic of plumbism?*

"Ah, there, Mrs. McD.: Have you been to this family's flat? Are the children eating the paint peeling off the walls?"

"Oh, yes indeed, Dr. L., and I'm tired of reporting it time and again. Also, this mother here is getting the money to feed her children but she just stuffs *their* food down her *own* gullet!"

So: the rehash of the same dreary, dreadful tale. Pica resulting from a parents' Uncontrolled Boulimia. With its ineffable bureaucratic efficiency the Welfare Department had the money to spend on a most expensive special garment for the hog-fat mother. The same department had no time to waste on miserable youngsters expiring on their feet of starvation and neglect. The festering slums besieging the medical school of my youth were still surrounding us; just being ever more tightly packed with



ravenous rats, more running roaches and more hungry humans.

My generation is supposed to have lost all bedside Humanism. Still, I stopped everything else and personally escorted the entire entourage to the pediatric emergency room. The wastelings were admitted to the ward, stat. The hospital administrator took charge of the situation.

Barely a few days later, a Falasha** Jewess waddled in to my office at the same hospital. Outrageously obese, she spoke an excellent English: very volubly.

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* The Sciences, vol. 9, #10, Oct. 1969, pp. 12-13.

Dr. J. Lanman stated that almost 500 cases of lead poisoning are treated at Kings' County Hosp. annually. NYC alone has 18,000 cases annually "as a conservative figure". *Daily News* p. 44, Nov. 13,1969.

** "Falasha" — Means stranger in Amharic — they refer to themselves as "beta Israel."

Without any pretense to theological expertise, we all know that world religions possess their own brands of aberrant offshoots; the Jews have their share. Thus, with a bow to the late Senator Joe McCarthy, I'm now looking at a pamphlet given to me on Mt. Gerizim on a 1968 visit. Adjacent to Nablus (the neo-polis built by Titus in 70 A.D. after he had leveled the Jerusalem of his day), it has on its crest a gleaming edifice: the Samaritan Synagogue. This pamphlet asserts that the Torah gracing the inside of their shrine was inscribed under the direction of Aaron, the brother of Moses, exactly 13 years after that great Founder's death . . . Why not 10 or 15 years? Will someone please do some carbon dating? All other Hebrews are just straying deviationists from the True Gospel.

The author of this revelation, the priest Amram Ishak, says nothing about latter day converts to Judaism such as the Crimean Khazars of the 7th century A.D., the Annamese and Chinese Jews, the ingathered, charcoal black "Ben Jehudi"



NOW living near Beer-Sheba, etc. In Genesis, we read about Noah and his three sons: Shem (*Semites*), Ham (*Hamites*) and Japhet (*Europeans*). Now the Falashas are a darker skinned splinter of Jews living in Ethiopia. Are they really descendants of the reputed romantic union of King Solomon and the Queen of Sheba? More likely, they are the progeny of King Solomon's Hebrew outposts planted along the upper Nile: converting, mingling with the indigenous *Agau* folk and thus creating an altogether unique offshoot of the Hebrew Faith. Whatever their true origins, these Jews of today are guided solely by the Torah—the Talmud and the Mishnah remain beyond their ken. Coptic Christian King Selassie is still inordinately proud of his sonorous title. "The Lion of Judah." Whether the wife of Moses, Zipporah, was a Cushite (i.e., an Ethiopian or a Copt or what have you?) does not seem to me (a mere M.D.) to be of earth shaking significance. I do think that the Hebrews have been color blind thruout their many migrations: precisely because so much racial intermingling occurred so early in their recorded history. The Norte Americano may find it strange that the Jews simply ignore the exact quantity of melanin present in the skin pigments of Yemenites, Karaites, or a presently American Jew such as Yaphet Kotto, the star in the smash hit, "The Great White Hope."

All tergiversations aside, it is a present day truism that the *Falashas* are a mere handful of Jews surviving in a sea of Coptic Christians. They appear to be inordinately proud of being *different*. This just may be the reason why the Falashas have haughtily stayed put and refused the opportunity of going to Israel. The Sciences, Vol. 10 #8, Aug. 1970.

All non-Falashas are mere "Kusha-Sha" —a most opprobrious term.

The widow of a Mohawk Indian, she had converted to Christianity before marrying an American soldier who had been stationed among her people. She had borne him many children; they had been very happy. Just two years previously, her husband had fallen to his death from a high steel girder. To the bereaved woman, this had been delayed, divine retribution for her unforgivable sin: she had strayed from the faith of her forebears. Before her wedding, she should have insisted that *he* become a Hebrew. Then the grieving widow had compounded her depravity by drinking raw lye and attempting to join her husband in the next world! Prompt intervention by the Brooklyn Hospital doctors had saved her life. The Falasha had reverted to the most scrupulous observance of Kashruth.

Her esophagus had scarred to a mere wanderling slit; a major reconstruction of her gullet was in the works. In the meantime, she could drink only homogenized foods. Yes, these were dreadfully fattening; she had *doubled* her previous weight of 150 lbs. She needed a second homogenizer so that she could avail herself of *meat* products in addition to the dairy.

In her hand, she displayed a properly made out Welfare Order and Medicaid requisition. Most of the day, she had been shunted from clerk to clerk who simply failed to grasp her pressing need. Brooklyn had no Falasha synagogue; she had no rabbi to guide her. I had a kind face; the name plate on my lapel sounded Jewish—would I please help her?

My original moue of distaste had become replaced by increasingly genuine sympathy. I called the Jewish chaplain of the hospital and explained to him her bewildered plight. Then, I lead the Cushite to a very intelligent and understanding social service worker; I signed the necessary forms certifying her urgent need. We are following further developments with the greatest empathy. She remains wholly convinced that she is totally damned beyond any hope of redemption; that God is letting her live only until her youngest son has been Bar-Mitzvah. Be that as it may, the Jewish community is increasingly helpful.

The third Gluttonously Gourmandizing Gal came to me within a month of the second. She is a Shinnecock Indian. The statistical probability of all three of my examples of the Pickwickian Syndrome being of Indian origin is so outrageously minuscule that one can only be amused at the actual fact of it being true.

Actually, I had first seen her some half dozen years previously when she had waddled in with a multiplicity of personal and family problems. After her husband's death, she had lost control of her growing children. The oldest son was "needling"; the barely teen age daughter had taken up with a pimp who was selling her favors—etc. The distraught mother had started eating inordinately. When I saw her she was chomping her way to 400 lbs. I had told her some unpalatable truths; the social service workers gave her all-out special attention. She was given real aid and she was grateful.

Now she needed me for some relatively small favors. The son had to have some recommendations for an excellent job. The self-same daughter needed a physical exam before going to college on a full scholarship. She was herself still obese but less than half her previous corpulent redundancy. Her present difficulties almost answered themselves. The widow was really voluble in her thanks.

It was just then that the thought of making a coherent Case Capsule anent my corpulent ladies came to me. Mrs. Lucinda Corpen was more than agreeable. She gave me an old

photo of herself taken when she was in the WACS in WW II. Now take CORPULENT and strike out the three letters, U, L, T, leaving CORPEN: will coincidental wonders never cease? Of course, these good looks were prior to having had the eight children AND the extra poundage: waist, 50″; thighs, 48″.

We could ramble on and on but let let us be terse and summarize. I trust that you begin to perceive the coherent etiological factor present in all of the tales exemplifying the Pickwick Syndrome. To me, the authors of the text books from which I quoted earlier appear to have missed the crucial point. First, most of the victims seem to be women. Second, they are members of the most disadvantaged stratum of society, especially when using economic criteria. Of course, this implies educational, social and many other deprivations. Third, and finally, there has to arise some extreme stress situation: sort of the last straw breaking the proverbial camel's back.

My portly ladies seem to present a "res ipsa loquitur". But there is still a last and crucial question. When the male sex is in the bind being discussed, it takes to drink: the men drown their sorrows in good old aqua vitae.

When women face insoluble problems they chomp away at food, just gulping down the calories. Men find solace in alcohol; women relieve *their* tensions by becoming champion trencher-performers.

Why the sociological difference? What is the modus vivendi?

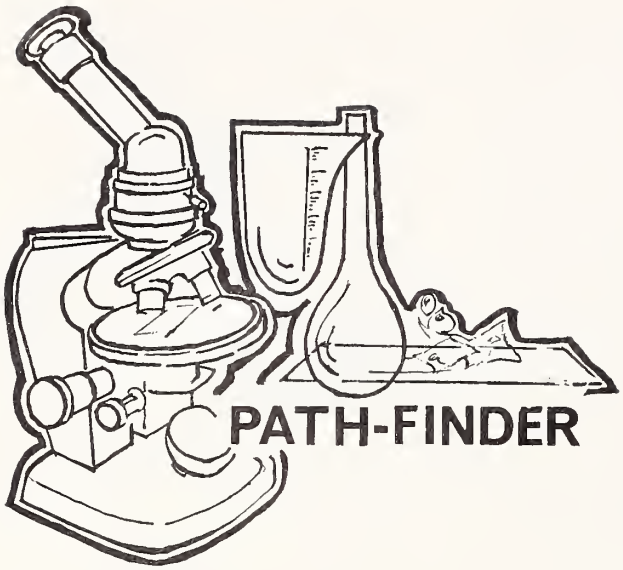
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MONTHLY REPORT—June 1971

Disease	June 1971	May 1971	Apr. 1971	June 1970	June 1969
Animal Bites	1467	1210	1291	1313	1153
Chickenpox	300	357	605	111	247
Conjunctivitis	171	218	215	142	121
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	28	20	33	25	9
Gonorrhea	522	527	559	697	566
Impetigo	75	79	81	95	58
Infectious Hepatitis	39	68	59	46	41
Infectious Mononucleosis	53	115	99	56	49
Influenza	351	810	2033	321	368
Measles					
Rubeola	559	720	704	16	15
Rubella	520	437	315	117	193
Meningococcic Meningitis	1	7	4	1	6
Meningitis, Other	5	6	8	0	2
Mumps	510	837	1123	191	236
Pertussis (Whooping Cough)	3	9	14	13	5
Pneumonia	257	295	445	275	146
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	577	724	1016	460	386
Syphilis					
Primary & Secondary	25	28	31	35	34
All Other Syphilis	87	83	126	150	131
Tinea Capitis	1	0	2	7	2
Tuberculosis (Active)	58	99	68	73	97



This series is intended to emphasize the importance of judicious selection and proper interpretation of newer laboratory procedures as applied to differential diagnosis of various diseases. It is edited by Leon L. Blum, M.D., Terre Haute.

Fluorescent Antinuclear Antibody Test for Lupus Erythematosus (FAA)

*ARTHUR C. JAY, M.D.**

Muncie

THE most accurate and sensitive diagnostic laboratory test for systemic lupus erythematosus (SLE) is the Antinuclear Antibody test using the immuno-fluorescent technique. The basis of this test is the development of 7.0S (or IgG) globulin antibodies in the serum of patients with SLE which, although not felt to be causally related, are at some time or other invariably present during the active disease.

During the fluorescent-ANA test, these antibodies react in a species nonspecific manner with the nuclei of various origins, including peripheral leukocytes of human or rabbits, calf thymus, rat liver, etc. This antibody-nuclear antigen pair then is reacted with fluorescein conjugated anti-human globulin, and viewed with a microscope utilizing an ultraviolet light source. A positive test is indicated by fluorescense.

Of these antinuclear antibodies, two are of clinical and diagnostic significance. These are:

1) Antinuclear desoxyribonucleic acid (Anti-DNA) which is probably diagnostic, when found, but which is present in only 2/3 of the patients with SLE, and cannot be used to rule out the disease.

2) Anti-DNA-protein which is not completely diagnostic in itself, but which is almost always present in SLE. Its absence is strongly against systemic lupus erythematosus. Other antibodies to nucleoli, histone, and a phosphate extractable antigen are present, but of unknown clinical importance. The "total antinuclear antibody" (Total-ANA) includes anti-DNA, DNA-protein, and phosphate extractable antigen, and does not differentiate between them. Its specificity is less, but it is never absent in SLE; therefore its absence makes the diagnosis of SLE highly improbable.

Since the "Total ANA" is less specific, there is a certain percentage of false positive reactions. These reactions are usually positive in a low antibody titer as compared to a positive test for SLE in which the antibody titer is usually high. A "Total ANA" test with a high titer (over 1/40), therefore, is of more diagnostic significance of systemic lupus erythematosus.

The false positive reactors include serums from approximately 15% of patients with rheumatoid arthritis, 1-2% of the normal population, and some persons with acute drug hypersensitivity, scleroderma, dermatomyositis, polyarteritis of the small vessel type, Sjogren's syndrome, active chronic hepatitis, and some patients with acute infectious hepatitis. A few individuals with atypical pneumonia, tuberculosis, lym-

* Ball Memorial Hospital, Muncie.

phoma, or anaplastic carcinoma will also have false positive reactions. All of these false positive reactions are usually in a titer of 1:40 or below.

It is worth repeating that in active SLE the "Total ANA" antibodies are usually always present, and will give a positive fluorescent antinuclear antibody test. This must be correlated with other clinical and laboratory data for the definitive diagnosis of SLE, and to rule out the small percentage of false reactors. Because of the significance of the antinuclear antibody test, it is the one of choice in confirming the SLE diagnosis. The fluorescent-ANA test should be done even if the patient is on steroids, as it takes 4 to 6 weeks of 40 to 60 mg a day of Prednisone to convert the test to negative.

Since the anti-nuclear antibodies are always present in SLE, it follows that a negative ANA test is of even greater significance in ruling out SLE since there are no false negatives. It is of importance that the same does not hold true for the LE cell prep, which has been the classic test for SLE. Reportedly, 50% of LE preps will be positive with one test, and 75% positive with multiple tests. The false negatives occur for a variety of reasons including technique, low antibody titer, or failure of phagocytic activity of the leukocytes. In these 25% of patients with negative LE preps, a diagnosis of SLE can be made by the serologic ANA test with demonstration of anti-nucleoprotein. In other words, the fluorescent-ANA test will be more frequently positive. The LE prep is of importance, however, in that it is more specific with fewer false positive reactions than the fluorescent-ANA test. It can be used to confirm the latter test, although a negative LE prep does not rule out SLE; whereas, a negative ANA test does rule out the disease.

One additional fact should be mentioned concerning interpretation of the antinuclear antibody test. Because of overlapping, both clinically and serologically, of the variety of collagen and other autoimmune diseases, some authors feel that they may be related immunological disorders. For this reason, some recommend that, if one test is positive, the serum should be subjected to two other tests for autoantibodies. For example, if the rheumatoid arthritis (RA) test is positive, a test for thyroid autoantibodies, and antinuclear antibodies for SLE should be done. This is done for a more comprehensive diagnostic evaluation of the patient.

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ELECTROCARDIOGRAM OF THE MONTH

Arrhythmias Complicating Myocardial Infarction: Atrial Fibrillation

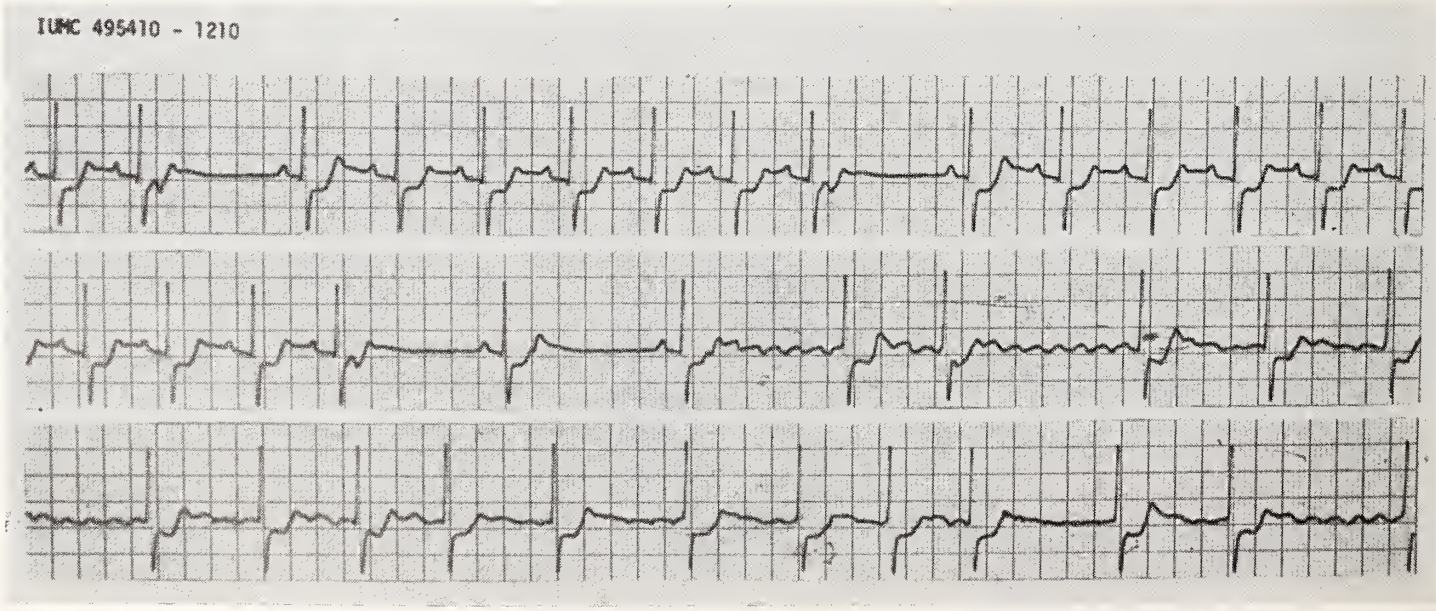
*CHARLES FISCH, M.D.**

Indianapolis

THE life threatening arrhythmias complicating myocardial infarction originate as a rule in the ventricles. Supraventricular arrhythmias, although quite frequent, rarely are life-threatening, except when, by the very nature of the rapid rate, they induce a drop in cardiac output of sufficient magnitude to result in shock, heart failure or coronary insufficiency. This differential is a most important consideration in the management of arrhythmias complicating acute myocardial infarction.

There are a number of interesting aspects dealing with the mechanism of supraventricular arrhythmias and the tracing under discussion is one such example. The continuous record was obtained from a 57-year old male during early phase of acute myocardial infarction and shows sinus rhythm at a rate of 100/min and a number of non-conducted (blocked) atrial premature complexes (APC). The third APC in the second row initiates a run of atrial fibrillation. It has been demonstrated that atrial fibrillation nearly

* From the Krannert Institute of Cardiology, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis 46202.



BLOCKED atrial premature complexes with the third in middle now falling during the vulnerable period of atrial recovery and resulting in atrial fibrillation.

always is initiated by an APC and most often the APC is closely coupled to the preceding sinus P wave. It falls at a time when the atria have not recovered (repolarized) completely and a reentrant propagation occurs between parts which have recovered and parts which are in various stages of recovery. This is the so-called vulnerable period of atrial recovery. A similar period exists during the recovery of the ventricles and a proper stimulus during that particular time leads to ventricular fibrillation. ◄

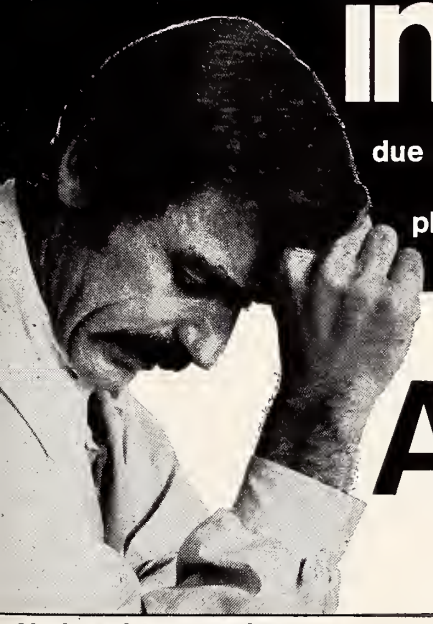
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LeJan Products has a bottle cap which can be opened only when each of its three dials is set at a prearranged combination. It fits all standard plastic or glass screw top containers. Wonderful to protect harmful liquids from children. Also adults who do not know the combination.

* * *

National Cylinder Gas announces a new blood pressure mercury manometer housed in durable Cycolac and with inflation cuffs in a variety of colorful fabrics. The manometer comes in off-white or blue. It and the colorful accessories are designed to add cheerfulness.

* * *

Rachelle Laboratories announces Furachelle (nitrofurantoin tablets, USP), in 50 and 100 milligram doses. Rachelle is one of the only two basic domestic producers of nitrofurantoin.

* * *

Diagnostic, Incorporated, of Indianapolis has a new kit which enables the physician to determine estrogen levels in his own office. Called Gyndex, the kit features four pre-calibrated slides for use with the vaginal smear technique. The kit is complete in itself with slides, insertion tubes, applicator sticks, cover glasses, a cellular dye and complete instructions.

* * *

Du Pont is introducing an automatic clinical analyzer which is designed especially for small-batch or single-test use. It has 24-hour availability and provides quick results. Eight different tests are available on the instrument now and four more will be added soon. This is Du Pont's first entry into clinical analysis but results from 40 years in instrumentation research and 10 years in analytical research for the chemical industry.

* * *

Stuart Pharmaceuticals is introducing the first chewable form of isosorbide dinitrate—CHEWABLE SORBITRATE®. Used in the prevention and treatment of angina pectoris, the onset of effect may be as quick as two minutes and relief may last as long as two hours. This is the fifth Stuart isosorbide dinitrate dosage form. The others are sublingual tablets and oral tablets.

* * *

Labconco Corporation has a new chair especially designed to accommodate patients with maximum comfort and security while blood is being drawn. Called the VAMPIRE, the chair is fitted with an arm wing which swings up to allow the patient to sit down and then is lowered in front of the patient. After an easy adjustment blood may be drawn from either arm without moving the patient or the wing.

Ames announces a new and improved method of measuring T-4. The new test, TETRALUTE®, requires fewer steps and less time than older methods. It measures total thyroxine in serum—both free and bound—giving information comparable to the more complicated PBI procedure.

* * *

Doubleday announces publication of "Psychedelics: The Uses and Implications of Hallucinogenic Drugs" by Bernard Aaronson and Humphry Osmond. Both authors are researchers in neurology and psychiatry. Osmond invented the term "psychedelics." The book is a broad and serious inquiry into the whole subject. It runs to 512 pages with index and illustrations. Cost $2.45.

* * *

Wyeth reports that clinical investigation has shown that many strains of the gonococcus, though resistant to ordinary therapy, will be controlled by large doses of aqueous procaine penicillin (Wycillin®). The high doses are thought to function by eliminating the less susceptible strains, thus preventing them from multiplying.

* * *

Eaton Laboratories has just published a booklet "Difficult Dressing Technics, 3: The leg." This is a companion piece to "1: The hand," and "2. The head." The monographs give special technics for use in areas that are difficult to bandage. Especially helpful for the ambulant patient. Copies are obtainable from Eaton representatives or by writing Eaton at Norwich, N. Y. 13815.

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Parke-Davis has added a new form of Chloromycetin—Chloromycetin Ophthalmic Solution. It is supplied as a sterile solution in a 5 ml squeeze-dropper package. Included in the package is a transparent plastic vial to enable the patient to see the contents, and an outer ultraviolet resistant amber shell to protect against light.

* * *

"What You Should Know About Drugs" was written by Drs. Gorodetzky and Christian after they had been asked to lecture on drug abuse in the fourth, fifth and sixth grades in Lexington, Kentucky. It is written especially for parents and teachers. Published by Harcourt Brace Jovanovich. Price $4.95.

* * *

Wyeth has a new addition to its Tubex line. Oxytocin injection, U.S.P. (synthetic), 5 U.S.P. units 0.5 ml, and 10 U.S.P. units 1.0 ml are now dispensed in the prefilled sterile cartridge-needle units.

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"Mary Rogers Fund" Established

Mary Rogers was a member of the editorial staff of THE JOURNAL for five years in the early 1960s. During this time she served as editorial secretary and later as assistant editor.

Since 1965 she had been an assistant editor for the National Retail Hardware Association and its publication, "Hardware Retailer."

Mrs. Rogers died on July 20, after a brief illness. In her memory and in appreciation for her many talented contributions to medicine and the Association Journal a special fund has been created in the Indiana Medical Foundation. Donations made to the Mary Rogers Fund will be assigned for purposes of endowing THE JOURNAL.

The endowment will be an ideal memorial for Mary. She was devoted to medicine and its literature. Her British heritage furnished a love for the English language and a dedication to the medical profession which was stimulating and inspiring. Her many artistic abilities will be suitably acknowledged by a living endowment which will help sustain THE JOURNAL.

Nearly All Hospital Statistics On the Rise

The economic statistics of hospitals do not all go up every year but most of them do. Hospital care for one patient for one day in 1970 cost $81.01. This is an increase of 15.7% over 1969.

Hospitals report an increase of more than this, namely 16.4%, in payroll expense. Wages and salaries for all community hospitals in the United States in 1970 amounted to $11.4 billion.

One reason for a fatter payroll is the increase in number of hospital employees as compared to the number of patients. The employee-to-patient ratio continues to advance each year. In 1960 community hospitals employed 226 persons per 100 patients. In 1969 the figure was 280. Last year it was 292.

Two statistics went down slightly. The occupancy rate in 1970 was 78%, down from 78.8% the year before. And, better yet, the average length of stay decreased during the same period of time from 8.3 days to 8.2 days.

Hospital births are on the increase again. The all-time high was 3,908,121 in 1961. This was followed by a decrease each year until 1969, at which time an increase to 3,319,315 was reported. There was also a still further increase in 1970 when the total went up to 3,537,000.

Despite the rapid growth in hospital expenses, the biggest increase concerns another aspect of hospital operation. Ambulatory care continues to be the fastest growing service in our hospitals. In 1970 there were 5.7 outpatient visits for each admission to the hospitals. This amounted to 181.4 million outpatient visits, an increase of 11.1% over 1969.

Guest Editorials

Deaths = Births

THE medical care system in the United States in undergoing increasing criticism. To some critics it seems so poor as to be labelcd a "non-system." Such a designation is meaningless, however, and disregards the fact that the vast majority of people in this country are receiving far better medical care than is available elsewhere in the world.

As the providers of medical care, physicians should be the first to recognize that the system under which they operate has some drawbacks. The major criticism by both medical

and lay spokesmen is that the system is geared to taking care of the sick rather than to keeping people well. This is the theme of many magazine articles including a report in *Scientific American* (Apr. 1970). The overriding premise in many of the arguments is that disease could be prevented if physicians were only interested in doing so. Seldom is mention made of the fact that MDs have long been active in numerous voluntary health agencies which advocate early diagnosis and treatment of all sorts of disorders before patients are able to recognize they are ill. Physicians are most often the responsible persons in federal, state, and local health departments who concern themselves with public health and preventive medicine.

Hopes that early detection would have a dramatic effect on the course and outcome of many diseases have not been fully realized. Most of the principal diseases to which the US population is subject can be modified only to a limited extent. From what we now know, it appears that early diagnosis is not enough. We must recognize those individuals who are particularly prone to a disease before the disease has developed. If we can change their proneness to certain diseases, we may make progress toward prevention. Even this statement largely remains to be proven.

Some progress has been made in detecting proneness to diabetes, coronary heart disease, gout and glaucoma, to name a few. Physicians certainly should support such efforts. They should also caution against undue optimism. No great change in the need for medical care or in the most effective type of medical care will be accomplished by such detection programs. The most we can hope for is an extension of the life span. Such an extension will probably require more medical care, not less. Efforts to prolong life can result in a longer period of disability and invalidism. An individual cannot achieve long, healthy, active life ended by sudden death or brief terminal illness by any knowledge currently available. Cliches urging physicians to be concerned with "wellness," not illness, mislead the public.

Statements such as those in *Scientific American* reporting: ". . .health testing serves to separate the well from the sick. . ." entirely oversimplify the problem of determining who needs to visit a physician. Many people with a whole battery of negative tests still need medical advice and care. Others with varying abnormalities either will not benefit from medical care, or will not accept medical care.

We do not need elaborate tests to tell us who is obese, who smokes cigarettes, who drinks too much alcohol or otherwise abuses his health. In spite of all the publicity, physicians represent about the only segment of the population that has modified its smoking habits. Fat consumption in the diet remains about the same and alcohol intake continues upward. Is it likely that detection of many other characteristics will do much good if their correction calls for any amount of individual effort, especially if the effort is unpleasant?

Much as we would like to be able to prevent disease rather than treat the sick, we are a long way from this goal. The choice is not between prevention or treatment. Rather it concerns adding more preventive measures to the present system of care. Any idea that this will lighten the load of physicians and make medical care more available to those who are sorely in need overlooks the obvious. There will always be one death for every birth!—***Massachusetts Physician*, April 1971. Reprinted with permission.**

Progress and Patience

AT long last we have arrived at a point where we can, with some certainty, describe the circumstances under which atherosclerosis is likely to occur. We still do not know the cause of this very complex disease or how to treat or prevent it, but knowing the human biological environment in which it flourishes is a sign of progress. This is the great contribution to medicine of population studies such as that presently being concluded in Framingham, Mass., described by Dr. William B. Kannel elsewhere in this issue.

It is now clear that atherosclerosis must be regarded as a disease inherent in the individual's way of life, a finding that, in itself, indicates further progress may be slow, and ultimate victory over the disease unattainable if it means changing our way of life. It is doubtful if the public can ever be persuaded to give up so many things they like on the chance they can avoid atherosclerosis and enjoy a few more years of life.

The Framingham Study concludes that the person who has normal blood pressure, uses little sugar, is neither overweight nor tense, doesn't smoke cigarettes or eat animal fats, and exercises frequently probably won't suffer from atherosclerosis. The operative word here is "probably," because no scientific authority on atherosclerosis, no matter how devoutly he might wish it, can assure the public that changing their life style will add years to their lives. It is still necessary for the sincere physician to garland what little he knows about atherosclerosis in a wreath of qualifying adjectives. We therefore have very little evidence with which to sell the public on the proposition that people should endure the privations necessary to live longer. Longevity is, after all, not its own reward.

Physicians cannot convince their patients until they themselves know more about the basic cause of this disease. This is one reason the exhortations of those who believe that in animals fats they have found at least one certain cause of atherosclerosis have a hollow ring. Consider the implications of the death rate in the medical profession, for example. Physicians are supposed to know how to stay healthy better than anyone else. Yet they die just as frequently from atherosclerosis as does the next fellow. And this point is even more strongly made when a cardiologist passes away, for they do not seem to live any longer than their colleagues.

All of which is not to say that physicians should not counsel their patients who have the disease as best they can. After all, when it comes to helping a patient who is suspected of having the condition, what else have we to tell him but that he should get some exercise, mind his weight, and cut down on whatever it is we think causes the "hardening" of his arteries? The patient is eager to do anything that will prevent his having a heart attack. The man who thinks he faces atherosclerosis or whose worst fears have been confirmed by a stroke or a coronary occlusion needs the buoyancy of expectation of ultimate recovery. He needs the succor borne of a conviction that he can still assert some influence on his own destiny. Without hope, man loses his will to live; without that will, he is lost. It is neither immoral nor unkind for the physician, no matter how many errors he may perceive in the assertions of his colleagues in research, to offer his patient the hope that a low-fat, low-sucrose, low-weight-and-more-exercise routine can afford. It is, however, quite another thing for medical scientists to be oblivious of the tenuousness of any theory that has as yet been put forward about the origin of this prevalent and fatal disease.

The educational campaigns against diets high in animal fats which have been carried on for the past twenty years have not been wholly successful; the death rate for atherosclerosis has not changed since they began. We need no more poignant reminder of this than the autopsy reports from Vietnam. According to unpublished data, among the thousands of healthy young men to have been killed in the Indochina war and come to autopsy, pathologists have discovered well-developed lesions of atherosclerosis in more than fifty out of every hundred soldiers examined. This is the same incidence observed among those killed in the Korean conflict twenty years ago.

There is yet one other point to consider. Even if our educational efforts were successful, and people could be persuaded to break century-old habits and change their way of living, they would still be faced with the dangers of hypertension and obesity, both of which play important roles in the etiology of atherosclerosis, and neither of which has been conquered by medical science.

Given the foregoing circumstances, it is understandable that some scientists have become so frustrated by the failure of their educational efforts they suggest that laws be passed which would force people to save themselves from this disease. The reaction is not unusual, but those who make such proposals should carefully consider the consequences. For one thing, it is a political fact that the public will not long endure any new law the wisdom of which they question. Anyone who doubts this would find a seance with Andrew J. Volstead enlightening.

Furthermore, when the government requires a person to do things to protect the individual from his own folly, it is usually abridging the individual's freedom of choice. It is acting not in behalf of society, which is its proper domain, but in the sententious claim that the government alone is possessed of superior judgment. This is why one cannot accept the idea that cigarettes should be banned, or that the cattle-raising, dairy, and food industries should be coerced by government into curbing the amounts of saturated fats in our diet. It has been suggested that the Congress and Food and Drug Administration do just these things.

There have been times when the FDA has been forced to bow to pressure from an impatient public, ill-informed on scientific matters. It is reassuring, therefore, to note that the FDA has shown admirable restraint in the development of new regulations affecting our food supply. It is to be hoped that in the face of the current something-must-be-done-about-heart-disease clamor, such steps as the Administration may be forced to take will not serve to freeze us in our present state of ignorance or stifle the search for the real cause of the affliction.

Physicians should remain dissatisfied with the current progress of research in atherosclerosis. The cure will come from an attack on the disease itself, not upon the way of life of the people who may suffer from it.—**Cortez F. Enloe, Jr., M.D. Reprinted from** *Nutrition Today* **May/June 1971, p. 14.**

Tragedy In Making

Two leading spokesmen of the U. S. medical profession have testified before the Senate Health Subcommittee on broad health care problems and the choices before the nation in how best to meet those problems. Both Dr. Max H. Parrott, chairman of the board of trustees of the American Medical Association, and Dr. Russell B. Roth, speaker of the

AMA House of Delegates, made it clear that all health problems are not medical problems, and that saddling the country with a monolithic government health care system would . . . "cast all 200 million Americans in the role of the guinea pig."

Dr. Parrott testified that many health problems would respond best to programs that are not purely medical, and pointed out that: "Our fat standard of living creates health problems. We ride in cars when we should be on a bicycle or on foot. We overeat. We overdrink. We smoke cigarettes. This affluent life style relates directly to the accident rate, the principal killer up to middle age, and to heart diseases, the principal killer after middle age."

Infant mortality rates, he points out, are linked closely to poverty at the other end of the economic scale. Cleaning up the ghettos would do more to solve this problem than a hundred Mayo Clinics. He concluded: "We did not attack malaria by doubling the number of hospital beds or tripling the number of doctors. We conquered malaria by draining the swamps!"

Dr. Roth stressed before the Subcommittee the AMA's proposed Medicredit bill which would assure the poor access to quality health care, help others purchase private health insurance through a sliding scale of tax credits, and insure everyone against financially catastrophic illness.

Medicredit is currently supported by 121 members of Congress.

One thing is becoming clearer each day. Until the views of Medical authorities such as these are heeded in the formulation of laws pertaining to health care, there is a better than even chance that health care services will go the way of the postal service. This would be a tragedy that would haunt the nation for generations to come.—**Tempe Daily News, May 1971.**

Editorial Notes...

The California Court of Appeals has completely absolved Winthrop Laboratories of any liability for impairment of the vision of a woman who claimed the damage resulted from use of Aralen. Said the court: ". . . adverse effect was an extremely rare result of use of a medication which has distinct value to mankind."

The American Pharmaceutical Association hopes to obtain repeal of laws and regulations which prohibit substitution of a drug for another without the specific consent of the prescriber. This is a vicious principle. The APhA is wrong. The APhA is right however in concluding that the repeal of antisubstitution laws, if eventually accomplished, is going to be a lengthy process. The Association presents printed forms designed to confer the physician's consent to specified pharmacists to substitute one drug for another in the same generic classification without consultation in each instance. The forms are designated as an interim step in the campaign. See *American Druggist,* April 5, 1971. The illustrated forms are filled in with an obvious popular appeal—the "doctor's" name used to complete the form is Welby.

The American Hospital Association is engaged in an educational campaign to open hospital doors to alcoholics who need hospital care. Association president, Dr. Edwin L. Crosby, says: "Many professionals believe the alcoholic patient will be disruptive, unmanageable, need special facilities, won't pay his bills and will require time-consuming and ultimately unsuccessful treatment." That outlines the problem fairly well.

The Canadian Diabetes Association recently announced the conclusions of its committee appointed to study the American report on oral hypoglycemic agents. The three-month Canadian study showed that: (1) The statistical evidence dealing with clinical variables was "not convincing," (2) A major area of cardiovascular data had been omitted from the study, and (3) Criteria for patient selection would render the study "irrelevant" even if the statistical methods were acceptable.

An atomic powered intracardiac pacemaker about the size of a .30 caliber bullet has been successfully tested in dogs for a year, reports the National Society for Medical Research. The nuclear battery has a projected life of five years. It is said that travelers planning to go abroad should obtain the permission of the atomic energy commission of the country they wish to visit. Also a good idea for them to avoid the electronic weapon detectors at airports.

The observation that germfree rats in the Notre Dame Lobund Laboratory have bigger, healthier bones than conventional animals, and maintain healthy bones well into old age, raises the question as to whether the difference might be due to the presence or absence of intestinal bacteria. Researcher Dr. B. S. Reddy finds that germfree rats absorb calcium and magnesium more readily and have more of the three control enzymes. He speculates that the germfree animal's greater supply of conjugated bile acids may account for this. In conventional rats the bile acids are mostly in unconjugated form, due to bacterial action.

Medical centers especially equipped and administered for the accommodation of ambulatory patients who require minor surgical procedures are being organized. An example is Surgicenter, an experimental center in Phoenix,

Ariz. The primary purpose was to provide facilities which would be adequate but which would not include in-hospital care. Further experience may show that such centers will be able to provide satisfactory out-patient surroundings at a considerably more economical level than the typical hospital out-patient department.

Products containing hexachlorophene, such as certain toothpastes or throat lozenges, may be harmful to children. The American Academy of Pediatrics warns that hexachlorophene intended for oral use or when applied to badly burned skin may be toxic. One small child died as a result of ingesting a few ounces of 3% solution. Generalized eczema should not be treated by applying hexachlorophene solutions. Parents should not allow children to have access to hexachlorophene products.

Two Rhode Island scientists have found that small doses of haloperidol will relieve severe narcotic withdrawal symptoms in humans. The drug is of European origin. It is marketed in the U.S. by McNeil Laboratories under the trade name of Haldol and is usually used in cases of severe agitation and anxiety. With the exception of patients who are addicted to very large doses of heroin, the drug will allow the withdrawal of heroin or of methadone, if it has been used to replace heroin.

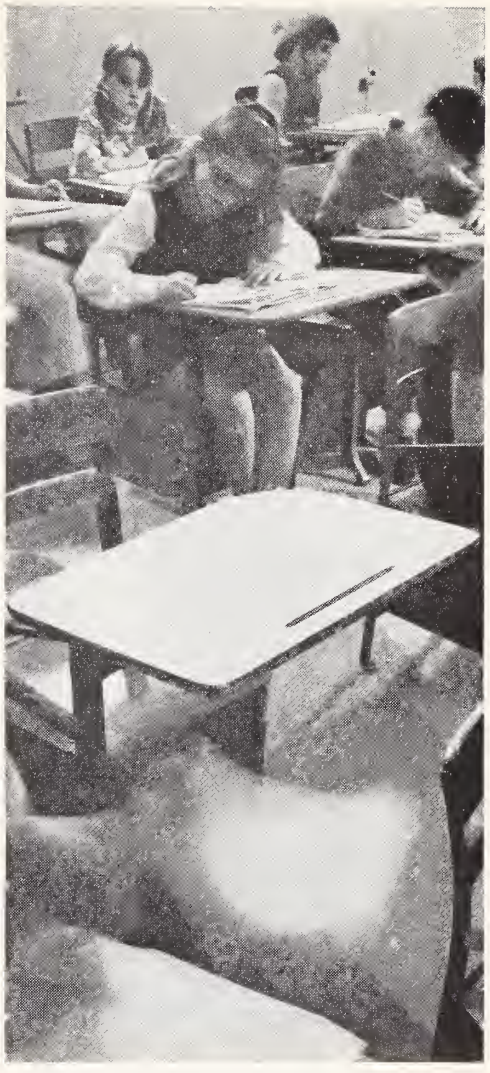
The Health Insurance Institute reports an outbreak of measles —the worst since 1966. Every part of the country is affected. It is primarily due to lack of vaccination. Of all new cases reported 95% are children who have not been vaccinated. The good word is "live measles vaccine is one of the most effective vaccines we have. But it doesn't do anybody any good if it remains in the bottle."

Metropolitan Life reports that while the highest death rates for auto accidents were associated with the 65 to 74 age group, both for men and women, since 1940 that group has become one of the safest, and the 15 to 24 group has the dubious distinction of the highest death rate.

A bill in Congress proposes to authorize the Veterans Administration to make agreements with five of the states to establish five new medical schools. Object: to help relieve the shortage of civilian doctors and especially to relieve the shortage of physicians for government services. Money would be appropriated to lease to the states selected excess lands, buildings and structures under the control of the VA, to convert these buildings to suitable facilities, and to pay the cost of faculty salaries during the first years of operation. One expected side effect of the program would be to enable the VA to increase the turnover ratio of patients in VA hospitals and thus reduce the cost of medical care.

When compared to the industrialized countries of western Europe, which resemble the U.S. in size, population, and in ethic and cultural considerations, mortality in white children in the first five years of life is found to be considerably lower in the U.S. The rate is also slightly lower than that for the Scandinavian countries plus the Netherlands.

As little as one-billionth of a gram of "hard" drugs can be detected within 15 seconds by use of a new system developed by the Syva Corporation, which is subsidiary of Syntex and Varian. The system is called FRAT(TM) for Free Radical Assay Technique. It is not only faster than the thin layer chromatography technics, but is less expensive. Tests by the FRAT system are under $1.50. ◄



The drunk driver.

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Drunk drivers kill and injure our children.

Last year, almost 6,000 children under 15 years old were killed in traffic accidents. Countless thousands were seriously injured.

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What can you do?

Remember, it's not the drink that kills. It's the drunk, the problem drinker, the abusive drinker, the drunk driver.

Remember, drunk drivers may be sick, and we've got to give them help.

But first we've got to get them off the road. For their sake and yours.

To find out what you can do, write the National Safety Council, Dept. A, 425 North Michigan Avenue, Chicago, Ill. 60611.

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Two County Medical Societies Declare Amphetamine Halt

NINETY-DAY moratoriums on prescribing amphetamines have been declared by two county medical societies and are now in progress.

The action was taken by the Allen County Medical Society in May and by the LaPorte County Medical Society in April.

Both projects have similar objectives. One is to determine which patients are relying on the "uppers" to an unhealthy extent or are selling some of their supplies to drug abusers.

The other is to evaluate the effectiveness of such an action in terms of decreased usage.

Dr. Raymond J. O'Brien, president of the LaPorte County Medical Society, has stated that the society is working closely with local police officials in an effort to plan an evaluation.

He has stated that if no decrease in amphetamine usage results, the next question will be, "Where did the drugs come from?"

In Allen County, Dr. Ronald J. Pancner, of the Interagency Drug Abuse Council and a psychiatrist, has stated that he sees a lot of teenagers in his practice who have their first contact with drugs from capsules obtained through prescriptions.

In both programs local pharmacists are cooperating. In Allen County, names of physicians who agreed to take part in the moratorium have been distributed to pharmacists and law enforcement officials.

All prescriptions for amphetamines bearing the signatures of these physicians are being considered forgeries for the duration of the moratorium.

In LaPorte County pharmacists are telling patients wanting refills that the amphetamines are being discontinued and suggest that they call their physicians for an alternative prescription.

Both programs have been praised by state police officials and the United States Narcotics Bureau in Indianapolis.

Dr. O'Brien believes that the programs, at the outset, were the first such efforts in the eastern United States.

The LaPorte County Medical Society, continuing its efforts, will introduce a resolution in the Indiana State Medical Association's House of Delegates in October asking for a statewide moratorium by all county medical societies.

The resolution will ask that the moratorium on such prescriptions not include treatment of narcolepsy, hyperkineses and certain psychiatric problems.

From *The Journal* 50 Years Ago

Christian Science is the greatest delusion of the times; the greatest insult to human intelligence; the strongest proof, if proof be needed, of our low intellectual standard. . . .

The objection to the Christian Science practitioner or "healer" is that he is uneducated in the laws of anatomy, physiology, pathology and the diagnosis of disease. He refuses to gather, compare, systematize, and analyze facts, or to deduce any system of knowledge from them. His is the same diagnosis and the same remedy for all ailments, no matter what their source or present development; and, therefore, his pseudo-science is based on the deification of ignorance.

What is the moral effect of Christian Science? What do church members think of a religion claimed to be the religion of Jesus, and yet asserting that its principles were discovered and revealed by an illiterate woman? . . .

Let the Christian Scientist believe in the non-existence of matter and the unreality of disease, but do not let him recklessly become the instrument of spreading contagious diseases, nor permit him to subject innocent and defenseless children to the horrors of neglect, and to the miseries of pain and sickness. "Christian Science: The Greatest Delusion of the Age," Editorial, *JISMA*, August 1921.

Morphine

JESSIE M. STEVENSON

Indianapolis

FREDERICK Wilhelm Serturner, an apprentice to the Royal Pharmacist Cramer of Paderborn, Germany, was the first scientist to isolate an alkaloid from plants. This discovery, made in the early nineteenth century, was contrary to the textbooks of that period which stated that plants and plant derivatives didn't contain alkaloids. The discoverer of morphine, Serturner, died without benefit of his own discovery.

Sixteen-year-old Frederick, least promising among a number of children of a widowed mother, did not want to become a pharmacist. He agreed to the apprenticeship because his mother was in need of whatever financial support he could give her. He became so bored with his work, however, that he "goofed off" as much as possible hoping he would get fired.

Herr Cramer, however, perhaps unknowningly, was quite a psychologist. He liked Frederick and was very sure he would be a good apprentice, although many folk in the village questioned his choice. Cramer began to ask Frederick to fix different kinds of equipment and instruments which were out of alignment. This was much more exciting to Frederick than wrapping up cakes of soap, filling prescriptions and gossiping with the customers. Finally Cramer challenged him with minor research, which he undertook wholeheartedly.

As a result of this new responsibility he began to question certain compounds himself—principally opium, dried poppy juice. This drug had been in use for many centuries. It could kill pain and produce sleep. However, it was very unpredictable as its effects were extremely variable. Frederick Serturner believed this was due to the fact that the true active principle of opium was unknown. Crude opium was a mixture of different substances; oily ingredients, salts and acids of various kinds. While in this state it was either too strong or too weak. Some folk to whom it was given obtained relief from pain, others did not, and some died from having been given too much.

Serturner was of the opinion that there was only one substance in opium which actually worked and that all other ingredients were useless. He carried on many experiments of an evening, after his long day's work in the pharmacy, in an effort to find this substance which would prove to be the active principle. He tried to isolate the element by using distilled water, then alcohol and other solvents. Finally he had an idea which paid off. He dissolved some opium in acid and then poured a bottle of ammonia into the solution. Shortly a batch of grey crystals appeared, but he was soon convinced that these did not contain the element he was looking for. The element *was* there but he had overlooked it.

After many more tests over a period of several months, he discovered very small white crystals among the grey and they proved to be an alkali; even though the textbooks had stated that plants didn't contain such an element. Thus Frederick Wilhelm Serturner, who had wanted to be an engineer instead of a pharmacist, after 14 years of tireless effort, became the first scientist to isolate the alkali from plants.

To prove, as he had suspected, that his newly discovered drug relieved pain and produced sleep, he began to carry out experiments at night on mice, rats, cats and dogs. He finally arrived at the dosage required for satisfactory results with animals.

At Cramer's suggestion he had written a report of his discovery of the grey crystals in the opium solution to Professor Trommsdorff at the University of Erfurt. The professor published the report but spoke of it as being the work of an immature scientist. However, when Serturner later discovered the white crystals he wrote a second report to Trommsdorff in which he stated that he had found the specific narcotic element of opium, the "Principium somniferum." Trommsdorff again published the report but this time he added an editorial note to the effect that there was still need for further research on opium.

This attitude of the great editor so infuriated Serturner that he resolved to forget all about the drug. He left Cramer's shop and moved to Einbeck in South Hanover. Having completed his apprenticeship, he became an assistant in a pharmacy. At first he refrained from doing any research but finally began to experiment with substances other than opium. But German scientists were ignored at the time, even in their homeland and he was unable to get any of his research published.

Even though he had vowed to have nothing further to do with opium, he was awakened one night by a severe toothache and he decided to take some of the drug which he had discovered. He believed it was safe for human use since he had, in his final experiments, been able to keep his animals alive. When he awoke, minus his toothache, from the profound sleep the drug had produced, together with some pleasant dreams, he said: "I will call this drug, morphine, after Morpheus, the god of dreams." This experiment on himself gave him the assurance that the drug could be used effectively by human beings. However, he thought that it should be tested further. He persuaded some of his friends to be "guinea pigs" for him. It is reported that he gave them, during intervals of one half hour, twice the amount of morphine which today is regarded as the maximum dose. They all are said to have survived after having experienced much discomfort, so much so, that they would not submit to any more experiments. Serturner realized that they had had an overdose which brought on the signs of poisoning they had experienced. Serturner, however, continued experimenting on himself.

After he had eventually determined the proper dosage for tolerance effectiveness in humans, he decided to write another report. But he had made up his mind not to give Trommsdorff the opportunity to insult him again. He sent this report to Professor Ludwig Gilbert of Leipzig, editor of the *Annalen der Physik*. Gilbert published it reluctantly. However, since this Journal received wide circulation, Joseph Louis Gay-Lussac, a professor of Physics at the Sorbonne, saw it and considered it to be of value. He said: "We do not fear to propose that the discovery of morphine will open a new field giving us precise active principles contained in many plants and animals."

As a result of this report and the favorable comments of Gay-Lussac, Serturner was given due credit for his new discovery in the field of chemistry. He was elected an honorary member of the German Mineralogical Society. The Philosophical faculty of Jena conferred a doctoral degree. In addition the Universities of Marburg, Berlin, St. Petersburg, Batavia, Paris and Lisbon conferred similar honors,

But along with his successes and triumphs he also met with disrepute from those in high places at some of the Universities, and by gossip characteristic of small towns. This situation, at least among the experts, was due largely to envy.

Other scientists began to declare that they and not Serturner had made the discovery first. Professor Ludwig Gilbert, who had not looked with favor upon the report which Serturner had sent him, came to his aid. When a certain Frenchman said that the discovery belonged to him, Gilbert proceded to write a paper in Serturner's defense, in which he proved beyond the slightest doubt that it was impossible for anyone else to lay claim to the discovery.

France settled the controversy by awarding him the Monthyon prize of 2000 francs "for having recognized the alkaline nature of morphine and having thus opened a way which has produced great medical discoveries."

All of this success and honor, however, was of very little significance to Serturner. His dream, that his discovery of the "greatest alleviator of pain the world had ever known" would be universally accepted, had not been realized. He left Einbeck and moved to Hamlin where he spent the remainder of his life; a disillusioned and disappointed scientist. He had found an effective way of relieving humanity of some of its pain, but humanity had been ungrateful.

The drug that he discovered which was intended to be of great benefit to mankind, became by its indiscriminate use, the downfall of many. Morphine addiction began to appear in the United States shortly after the Civil War. It had been administered to the wounded soldiers.

On February 9, 1909, the Congress of the United States passed an Act to prohibit the importation and use of opium, of which morphine is a derivative, for other than medicinal purposes. This Act has been amended by Congress after Congress. In 1968 the 90th Congress, through the Federal, Food, Drug and Cosmetic Act, made the penalities for violation much greater than when they were first imposed.

At one time morphine was thought to be a cure for opium addiction; later heroin, a morphine derivative, was thought to be a cure for morphine addiction.

Opium, and morphine and heroin, it's derivatives, comprise the opiates that have been used by addicts in this country. In 1930 opium was surpassed by morphine among drug users, but today the preferred drug is heroin, of which there are reported to be 65,000 addicts.

Frederick Wilhelm Serturner, without help, training, or the proper equipment with which to work, became one of the world's greatest scientists, the first to isolate an alkaloid from plants, and by so doing converted impure opium into dependable morphine.

The hypodermic needle and the process of hypodermic injection didn't become medical knowledge until 1853. In his last illness Serturner became too weak to swallow and since his death occurred in 1841, at age 57, his suffering could not be alleviated by the drug which he had discovered. by the drug which he had discovered. ◄

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A triumph over trichomoniasis

The male urogenital tract is by far the main source of reinfection in trichomonal vaginitis.

It follows that neglecting to treat infected male partners of women with trichomonal vaginitis invites therapeutic failure.

Just as Flagyl is the best agent available for eradicating trichomonal infection from extravaginal sites in women, it is the only agent capable of eradicating demonstrated trichomonal infection in men.

Because of published reports of consistently high cure rates—often up to 100 percent—and a relatively low incidence of side effects, Flagyl has become the agent of choice for trichomonal vaginitis.

Indications: For the treatment of trichomoniasis in both male and female patients and the sexual partners of patients with a recurrence of the infection provided trichomonads have been demonstrated by wet smear or culture.

Contraindications: Evidence of or a history of blood dyscrasia, active organic disease of the central nervous system and the first trimester of pregnancy.

Warnings: Use with discretion during the second and third trimesters of pregnancy and restrict to patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers. It is not known whether this can be injurious to the newborn.

Precautions: Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. There is no accepted proof that Flagyl is effective against other organisms and it should not be used in the treatment of other conditions. Exacerbation of moniliasis may occur.

Adverse Reactions: Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia*, exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, drowsiness, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weakness," urticaria, flushing, dryness of the mouth, vagina or vulva, vaginal burning, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified.

Dosage and Administration: *In the Female.* One 250-mg. tablet orally three times daily for ten days. Courses may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used* one 500-mg. insert is placed high in the vaginal vault each day for ten days and the oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment. Do not use the vaginal inserts as the sole form of therapy. *In the Male.* Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner.

Dosage Forms: Oral tablets 250 mg.
Vaginal inserts 500 mg.

References available on request.

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In view of the alarming increase in reported cases of infectious syphilis and because gonorrhea is now pandemic in the United States, the Council on Environmental and Public Health, American Medical Association, has prepared the following statement for the information and guidance of medical societies

Statement on Venereal Disease

THE American Medical Association Council on Environmental and Public Health reports that gonorrhea ranks first and syphilis third among the reportable communicable diseases in the United States. For the year ending June 30, 1970, infectious syphilis rates were eight percent higher nationally than a year earlier, with annual increases spread over 33 states and an estimated incidence between 70-80,000 reported cases; there are 250,000 cases of all forms of syphilis estimated to be diagnosed and treated each year.

At the same time, gonorrhea morbidity exceeded 573,000 reported cases. Gonorrhea is pandemic in the United States, with an estimated two million cases.

The Council urges medical societies to acquaint their membership with the growing and alarming dimensions of the VD problem. Physicians should take all appropriate measures to reverse the rise in venereal disease and bring it under control.

Physicians in private practice treat approximately 80% of the syphilis and gonorrhea that comes to diagnosis but report to public health departments only one out of every eight cases of syphilis and one out of every nine cases of gonorrhea they treat. Physicians should assist public health departments by reporting the VD cases they treat. Medical societies are urged to cooperate and give broad support to public health authorities. Much effort must still be made by health departments and medical societies to foster mutual trust so that public and private medicine can work effectively for the control of both syphilis and gonorrhea.

The Council also urges medical societies to continue efforts for the enactment of state laws to permit physicians legally to treat VD cases of minors without obtaining parental consent; 29 states and the District of Columbia now have laws which permit physicians to treat a minor for VD without adult consent.

The American Medical Association is making VD a national theme for Community Health Week-1971, with suggested dates of October 17-23. Informational and promotional material will be available for medical societies. The AMA publication *PR Doctor*, January 1971, featured the problem of venereal disease, which included reports of excellent programs under way by state medical societies.

The Council encourages the publication of more articles in professional journals on veneral disease and its control for the guidance of the profession. Medical societies are asked to support education of patients and the public through more extensive and imaginative use of all available media and through school curricula. ◄

Welfare
Past - Present - Future*

IRVIN W. WILKENS, M.D.

Indianapolis

BECAUSE of the many changes in welfare legislation that have taken place on the county, state and national levels, it has been impossible to prepare this article sooner. And even now the way is not entirely clear as it will take time to evaluate and interpret the laws that have been passed. Going on from the previous discussion of the present state of the welfare program, I will discuss its future.

Like all other states Indiana is beset with many grim problems. The order of their importance depends on who is evaluating them. Most people would list inflation, racial conflicts, increase in drug addiction, the war in Vietnam, unemployment and pollution as most important. But for sheer magnitude the welfare problem with its estimated national cost this year of $15 billion overshadows them all. The need of more and more people for food, housing, and adequate maintenance has caused the program to intensify with appalling rapidity and several states have become bankrupt as a result. No definite goal has ever been set for the future, primarily because there was no way to judge what the development of the program would entail; consequently, it has mushroomed with frightening speed. The inability of the states to meet the financial drain may well result in forcing the federal government to underwrite the whole program. Since the problem is so huge, we need to study the reasons for the phenomenal upsurge of applications for help.

In assessing the people who come under the welfare program, it is easy to place people in categories. This is a mistake. We cannot say that the typical welfare recipient is lazy, unwilling to work, a school dropout, a ghetto dweller or aged; yet, at one time or another, we have all heard these sterotypes used as explanations for the increase in the number of people who ask for help. Investigation, however, shows that many types of people are involved and that need cuts across many segments of society —the old and the young, the skilled and unskilled, the educated and the dropouts, the metropolitan and the rural dweller. While some groups may produce more cases than others, there is no typical welfare recipient. Even members of affluent groups may find that circumstances reduce them to the position of asking for aid; for example, a recent case concerned a man who, for eight years, had commanded a salary of between $60,000 and $70,000 a year. Three years of illness had used up all his resources.

There are many reasons for the great increase in the numbers of people needing help. In the first place, there are so many more people today; the population has increased tremendously in the past 25 years and even in the past 10. Furthermore, people are crowded in comparatively small areas. The desire and the ability of neighbors to take care of the ailing and the indigent as they did in earlier, less sophisticated times, no longer is adequate. People do not know their neighbors and, indeed, through church and other organizations are more apt to help the needy in other lands than those in their own community. As people live closer and closer together, they are farther and farther apart in their knowledge of each other's needs.

Also, people are living longer today. Modern medical practices have increased the life span of millions of people and this, desirable as it may be, has compounded welfare problems. The aged are still afflicted with those incapacitating infirmities that come with years—vascular problems, heart, renal and cerebral ailments, diabetes, and those injuries from falls that finally put many of them in nursing homes to wait out their days. In only too many of these cases the families cannot provide professional care and the elderly invalid becomes a public charge.

Unemployment forces many to seek aid. This problem has always been with us but it, too, has been aggravated by the improvements in our way of life. In earlier times there were jobs for those strong in body, no matter how unskilled they might be, but now muscle power has been replaced by mechanical power. Our technological advances have made life easier and goods more abundant but have found no solution for using the

* Part 3, continued from March.

unskilled. In many cases the unemployed are unemployable, and the cost of training such people for skilled work would be astronomical, even if there were any guarantee of a job when they were trained. The safety valve for unemployment years ago was taking up land and starting on one's own, but the land no longer is there for the taking and the only alternative is to go on the public welfare rolls.

Oddly enough, there is another phase of unemployment that is a paradox. At the present time there are thousands of highly skilled and well-trained people out of work. The cutbacks in the aircraft industry, in the tions in business, have thrown these space program, in executive posi- people on the labor market at a time when the need for their skills has diminished. All of their college training and their job experience are not finding work for them now. Thus we find ourselves on the horns of a dilemma—unemployment of the unskilled because they are untrained, and unemployment of the highly skilled because there is a decreasing need of their skills.

Probably one of the greatest causes of the expansion of the welfare program is the changing philosophy of modern times. A few years ago the idea of going on welfare had an aura of disgrace about it; most people had a horror of it. But in recent years there has been a lessening of personal responsibility and a corresponding increase in willingness to let the government take over. For some people whose families have been on welfare for a long time, this is a way of life and they not only accept it but expect to be cared for. However, there are thousands to whom this is a new experience but here, too, there is a feeling that it is the government's responsibility to see that all are adequately fed, housed and cared for. From the "laissez-faire" policy of the government in this area 50 years ago to the assumption by the government of this tremendous responsibility now is a gap that the welfare program is trying to fill. How successfully it will be done will be shown in the future. At the present time and in the immediate future the problems seem overwhelming.

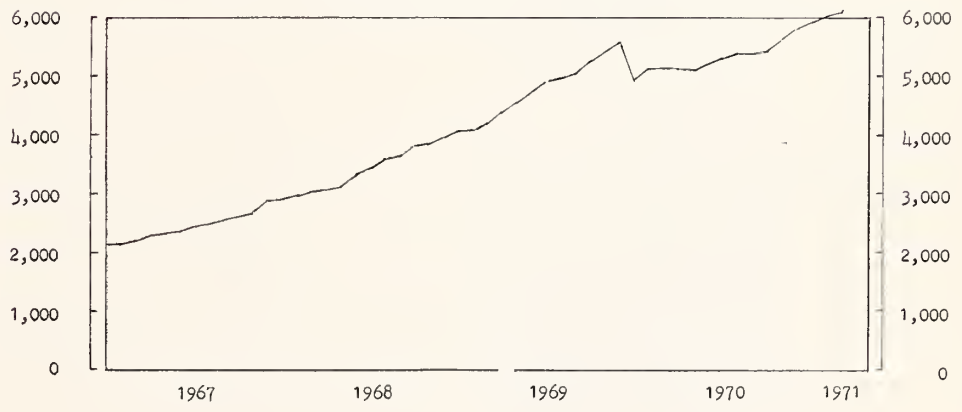
The following legislation was passed in the 1971 Indiana General Assembly affecting Public Welfare:

S.B. 126 Provides for legally responsible persons for applicants for Public Assistance who are physically or mentally incapable of completing their applications or managing their affairs.

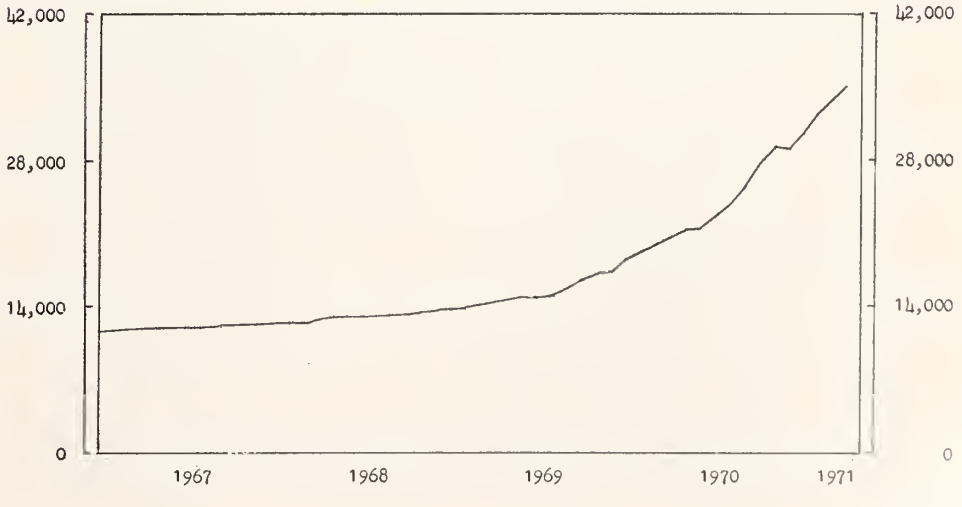
S.B. 161 Provides for the appointment of a responsible person as indicated above but only for Old Age Assistance applicants (a legal opinion will be required as to which of these bills will take precedence).

S.B. 238 Provides one thousand dollars ($1,000) tax exemption for certain individuals 65 years of age or over if the assessed valuation of their real estate does not exceed $6,500 with income not in excess of $6,000.

MONTHLY CASELOAD FOR ASSISTANCE TO THE DISABLED
FROM JANUARY 1967 TO MARCH 1971



AVERAGE MONTHLY CASELOAD FOR AID TO DEPENDENT CHILDREN
January 1967 to March 1971



S.B. 337 Requires the supervision of a licensed child-placing agency or a county department of public welfare prior to the adoption of a child by non-related adoptive parents.

S.B. 600 Permits not-for-profit day care nurseries to operate such facilities without regard to certain restrictions relating to physical requirements for day nurseries.

S.B. 625 Provides for an increase in an amount of cemetery expenses from $100 to $150 for recipients of Public Assistance and provides for an increase from $250 to $350 in the amount which may be contributed by friends and relatives or from resources of the deceased.

H.B. 1193 This provides the same increases as does S.B. 625. However, H.B. 1193 permits payment of funeral expense for the parents in the Assistance to Dependent Children category. Therefore, a legal determination will be needed to determine which of these bills has precedence.

H.B. 1392 This bill increases the monthly maximum amount that can be paid to a recipient of Assistance to Dependent Children. The total amount paid to any dependent child for any calendar month is increased from $50 to $65 and the total amount paid to the person essential to the well-being of such dependent child for any calendar month remains at $50. The total amount paid to one (1) dependent child and to the person essential to the well-being of such dependent child for any calendar month is increased from $100 to $115. If there is more than one dependent child in the same home the total amount that can be paid for any calendar month is increased from $25 to $30 for each additional child or children. Also if an incapacitated father of such children is living in the home, this bill increases the maximum monthly payment for the father from $25 to $30. This bill became effective April 1, 1971 and was necessary in order that the State remain in conformity with federal requirements.

H.B. 1692 Provides that recipients of Old Age Assistance who are veterans and are in need of a guardianship have the bonding provisions for Veterans Administration Guardianship apply.

H.B. 1779 Requires township trustees in Class A townships (population 250,000 or more) to take advantage of the Food Stamp Program. This only involves three townships (Calumet and North in Lake County and Center in Marion County).

H.B. 1869 This bill was approved and provides for an increase in the State monthly maximum assistance payment to recipients of Old Age Assistance from $80 to $100. Since an emergency exists, this legislation became effective July 1, 1971.

1969 Legislation Enacted at the 1971 Session:

S.B. 56 Introduced in the 1969 session of the General Assembly, provided for an increase in the monthly maximum for Blind Assistance recipients from $95 to $125 and also provided for payment of care in licensed boarding homes up to $200 per month; was vetoed by the Governor during the 1969 session. This veto was overridden by the Legislature in the 1971 session and became effective February 1, 1971.

Legislation Introduced But Not Enacted:

Several bills, some of which the Department of Public Welfare considered good and some not so good, were introduced but were not enacted. One of the most significant bills which failed was S.B. 626, which would have increased the monthly maximum for recipients of Disabled Assistance from $80 to $100. This bill would also have made possible the increase of the monthly assistance award up to $200 for the payment of care in a licensed boarding home.

Indiana Medicaid Program

Recipients By Category

March and September 1970

and February and May 1971

Category	1970 MARCH	1970 SEPT.	1971 FEB.	1971 MAY
01 Old Age Asst. Money Payment	17,766	17,120	19,799	19,423
03 Blind Asst. Money Payment	1,282	1,360	1,443	1,407
04 Disabled Asst. Money Payment	5,491	5,864	6,997	7,483
05-A ADC Children Money Payment	58,887	74,709	89,464	100,013
05-B ADC Adult Money Payment	19,771	26,411	32,907	37,032
06 Old Age Asst. Medical Only	3,353	6,657	7,415	8,110
07 Blind Asst. Medical Only	114	156	176	187
08 Disabled Asst. Medical Only	394	916	1,224	1,463
09-A ADC Children Medical Only	205	308	365	397
09-B ADC Adults Medical Only	86	137	172	203
Total	107,349	133,638	159,962	175,718

H.B. 1862 Would have made stepfathers responsible for the support of stepchildren, thus reducing the Assistance to Dependent Children caseload accordingly.

Statistical Evaluation

The following is the current statistical evaluation of the various programs.

During the calendar year ended December 1970, expenditures in the United States for all forms of public assistance amounted to $14.4 billion, an increase of $2.9 billion or almost one-fourth more than the preceding year. Expenditures for maintenance assistance rose by 28% and for medical assistance were one-fifth more than in 1969.

Indiana Title XI and Title XIX Programs

Vendor Payments by Provider Type

January 1, — May 31, 1971*

TYPE PROVIDER/SPECIALTY	# CLAIMS/BILLS	$ PAID
A. Institutions:		
Hospitals	60,282	$ 7,539,381.02
Skilled Nursing Homes (SNH)	6,128	4,278,145.35
Intermediate Care Facilities (ICF)	40,763	16,809,907.17
Home Health Agencies (HHA) and Rehabilitation Centers (RC)	2,342	155,134.32
B. Practitioners and Suppliers:		
Pharmacists	959,189	3,645,047.49
Physicians	190,400	3,882,916.93
Dentists	23,196	1,029,113.72
Podiatrists	2,491	34,106.69
Chiropractors	642	15,140.78
Suppliers	38,100	995,459.41
	1,323,533	$38,384,352.88

* Includes payments disbursed through June 4. These are unaudited figures and are subject to adjustment.

Indiana Title XI and XIX Programs

Participating Practitioners and Suppliers

As of May 31, 1971

SPECIALTY	NUMBER	PERCENTAGE
Physicians	3,977	79%
Dentists	1,213	54%
Chiropractors	243	85%
Pharmacists	1,156	96%
Optometrists	523	99%
Podiatrists	205	100%
Suppliers	990	—
Total	8,307	

In January 1971 almost 14.0 million Americans received cash public assistance payments. Total payments for both maintenance and medical assistance amounted to $1,370 million in January 1971.

During the first 7 months of the fiscal year 1971, expenditures for medical assistance in this country came to $3.4 billion.

From the figures noted in the charts and the statistical reports showing the tremendous increase in the recipients and the cost involved, it is evident that the program has gone far beyond the capacity of the states to carry.

Until the new Federal legislation is put into final form and the balance between the federal and state governments' shares defined, we can only surmise that the Welfare program will ultimately become completely Federal in nature.

That this eventuality will bring a staggering number of changes in administration is a foregone conclusion and that it will upset many of our present conceptions of the role of the federal government is equally apparent.

Where is Welfare going? We certainly do not want an overall public assistance program, which failed as early as 1620, and will probably finalize in a period of change, expansion, and manifold problems. ◄

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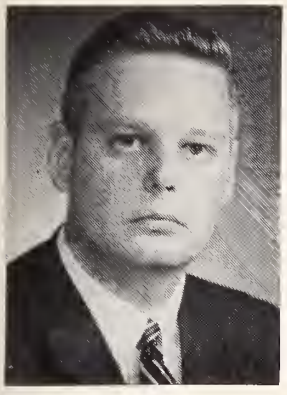
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TAX TIPS

by LAWRENCE A. JEGEN, III

Mr. Jegen is o professor of law ot Indiana University Indionopolis Low School, specializing in toxotion, business ossociotions ond estote plonning. Professor Jegen urges the reoder to consult the reader's lawyer before opplying the data in this orticle to a particulor fact situation.

THE 1971 General Assembly made a significant change in the age at which an individual may devise property by a will. Henceforth: any person of sound mind who is 18 years of age or older, or who is an infant and a member of the armed forces, or of the merchant marine of the United States, or its allies, may make a will. As a consequence, you should tell your 18-year old children about this change and then you and your children should consult your lawyers as to how this change affects you and your plans.

Further, you should ask your lawyer to review your wills and trusts in light of the fact that the 1971 General Assembly enacted a new Indiana Trust Code.

Beginning January 1, 1971, taxpayers are entitled to credits against their Indiana Individual Adjusted Gross Income Taxes, not only for charitable contributions made to institutions of higher education located within Indiana, but also for any charitable contributions to any corporation or foundation organized and operated solely for the benefit of any such institution of higher education or to the associated colleges of Indiana. Thus, you may now give charitable contributions to such organizations as the Indiana University Foundation and the Rose-Hulman Institute of Technology—and be entitled to a credit against your Indiana Adjusted Gross Income Tax.

One type of investment that is still an excellent one from the economic and tax standpoint, even after the Tax Reform Act of 1969, is an investment in breeding cattle. An individual may invest in the cattle, depreciate the cattle over a short useful life (taking high ordinary income deductions), and then sell the cattle at a gain that is significant—and which generally consists of some long-term capital gain. Frequently, persons who invest in this type of investment do not even see the cattle that they own, though a trip to examine the cattle generally is deductible.

Another investment that is rapidly becoming popular as an excellent investment is to form a Subchapter S corporation—with other investors, at a cost of about $10,000 per shareholder—for the purpose of producing chicken eggs. The investment return and tax-advantages are extraordinarily impressive and the businesses are operated here in Indiana. Further, banks frequently will loan an investor his entire investment.

Senator Ribicoff has introduced a bill in the United States Senate that would require persons other than lawyers and C.P.A.s to pass a test to be certified (as a licensed tax return preparer) in order to be allowed to prepare more than 25 tax returns, for a fee, per year.

The Chamber of Commerce has computed that on or about May 10, 1971, the average American taxpayer finally earned enough money to pay for all his federal, state, and local taxes. On the other hand, the IRS is concerned that the average American will be required to pay considerably more income taxes than he suspects when he files his 1971 federal income tax return, because the federal withholding tables are not computed to adequately withhold sufficient taxes. Thus, employees should check with their employers to be certain that sufficient amounts of income taxes are withheld from the employees' wages. Further, at the rate that professional persons' fees are increasing, you might check your own estimated tax payments to be certain that you are not grossly underpaying your estimated income taxes for 1971.

Recent IRS statistics indicate that taxpayers are smoking less but drinking more alcohol. While I am not certain that the switch is for the better, I question the philosophy of a lawyer who told me that he started drinking, in order to thin his blood and counteract the restricting effect of his smoking.

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Drug Information Sources Reported by ISMA Group

JAMES B. JOHNSON, M.D.

Greencastle*

THE Commission on Public Health has made a four-months study of the availability of materials and methods for developing a program to obtain information regarding non-medical drugs and euphoriant agents for the guidance of ISMA membership, in accord with Resolution 70-27, Standards of Non-medical Drugs.

It was found that over a period of fifteen years or so, the Indiana State Board of Health has developed an extensive medical and lay bibliography on these subjects. These materials, including a film catalogue, teachers' guides (K through 12), treatment and rehabilitation bibliographies, drug education bibliographies, and pass-out pamphlets and leaflets are readily available to all members of the Indiana State Medical Association upon request.

This means of communication is also used to make all members aware that the May issue of *The Journal* of ISMA had as its main theme, "DRUG ABUSE." Interested members will find this *Journal* issue also a source of information.

Those members interested in bibliographic summary of drug abuse may contact Mr. Willis Roose, Director of Drug Control Division, Indiana State Board of Health, Indianapolis 46206.

Anyone interested in materials available to schools for drug education is encouraged to contact, as a resource person, Malcolm A. Mason, Director, Division of Health Education of the Indiana State Board of Health. ◄

* Chairman, ISMA Commission on Public Health.

Congenital Defects Defined in Publication for Parents

A completely reorganized and updated edition of a booklet entitled "If Your Child has a Congenital Heart Defect" has been published by the American Heart Association for use by parents of children with operable defects, by organizations for crippled children and by rehabilitation services.

The publication is intended to prepare parents for events that may follow the preliminary diagnosis, including further diagnostic tests, hospitalization, surgery, convalescence and the transition to normal living. It features sections on surgery for congenital defects, information on state services for crippled children's services, vocational rehabilitation programs and visiting nurse services and diagrams which enable physicians to illustrate a child's particular heart defect.

Copies of the 45-page publication may be obtained through local Heart Associations or the AHA Distribution Department, 44 E. 23rd St., New York 10010.

Letters

to the editor

July 28, 1971

To the editor:

Due to the backlog of registration applications and the heavy demand for order forms resulting from the recent shift of amphetamines and methamphetamines to Schedule II, an extension of time is necessary in order to process this backlog.

The Bureau's extension on registration for practitioners, which was to expire on July 29, 1971, has now been further extended to October 1, 1971. This further extension means that:

1. *Pharmacists* may continue to fill practitioner's prescriptions for controlled substances without a registration number, provided they exercise professional judgment to ensure that the practitioner is legally authorized to practice and that the prescriptions contain the following statement: "Federal registration applied for on ..... (date)."

2. *Manufacturers* and *Distributors* may continue to sell Schedule III through V controlled substances to practitioners without BNDD registration numbers, provided they have checked authenticity of the purchaser and the following statement is placed on all orders: "Federal registration applied for on ..... (date)."

This extension, to October 1, 1971, also applies to the use of order forms for amphetamine and methamphetamine drugs and combination products. Registrants who have order forms in their possession *are required* to use them as of August 6, 1971, for the purchase of these drugs without regard to the extension period. However, registrants not having order forms will be permitted to purchase amphetamine and methamphetamine drugs without order forms until October 1, 1971, provided the supplier checks the authenticity of the customer and that he is authorized under state law to purchase the drugs.

The drugs Biphetamine, Biphetamine-T, and Fetamin have now been transferred to Schedule II, after the makers withdrew their requests for hearings. The effective date for the requirement of order forms, separate records, written prescriptions, and the non-refilling of prescriptions for these drugs is August 23, 1971. Registrants having order forms in their possession must use them to purchase these drugs as of August 23, 1971. Registrants not having order forms may purchase the drugs as outlined above until October 1, 1971.

All amphetamine and methamphetamine drugs that were required to bear the CRx symbol under the former Drug Abuse Control Amendments are now in Schedule II of the Controlled Substances Act, except for the drug Eskatrol. This drug remains in Schedule III pending a hearing set for August 16, 1971.

Physicians and pharmacies handling amphetamine and methamphetamine products transferred to Schedule II will be regarded as being in compliance wi'h the security requirements of the Controlled Substances Act if they continue to comply with Schedule III security, which would include the dispersal of these drugs throughout their regular stocks. Schedule II security requirements for physicians and pharmacies will apply to these drugs as of October 1, 1971.

Proposed security controls for manufacturers and distributors were published in the Federal Register on Wednesday, July 21, 1971.

Registrants having any doubts should contact the nearest BNDD Regional Office before filling controlled substances prescriptions or orders.

Sincerely,

FREDERICK M. GARFIELD
Assistant Director for
Scientific Support
Bureau of Narcotics and
Dangerous Drugs
United States Department
of Justice
Washington, D.C. 20537

Editor's Note

The following is a brief outline of the revised schedules under the new law:

SCHEDULE I:

Schedule I contains substances with a high potential for abuse that have no currently accepted medical use. (marijuana, LSD, STP, peyote, etc.)

SCHEDULE II:

Schedule II contains the former "Class A" narcotics, injectable methamphetamine and almost all amphetamine preparations.

SCHEDULE III:

Schedule III consists of the former "Class B" Narcotics and the majority of the DACA drugs. (DACA drugs — barbiturates, glutethimide, etc.)

SCHEDULE IV:

Schedule IV contains drugs classified before as DACA drugs which have a lower abuse potential than those in Schedule III. (Phenobarbital, chloral hydrate, meprobamate, etc.)

SCHEDULE V:

Schedule V consists of the former "Class X" products — both prescription and over-the-counter items.

when manhood ebbs... or is delayed due to testicular hormonal insufficiency

What nature denies, Halotestin may replace. That's the purpose of this orally active androgen in conditions such as impotency, eunuchoidism, and eunuchism. The most widely used agent of its kind, Halotestin is replacement therapy with approximately five times the potency of oral methyltestosterone. And, at its recommended daily dosage of 2 to 10 mg., Halotestin is economical as well as convenient. Of course, you will want to employ androgens carefully in young boys to avoid premature epiphyseal closure... and in the elderly where possible sodium retention may, minimally, precipitate edema. Tablets of 2, 5, and 10 mg.

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Please see facing column for summary of contraindications, precautions, and adverse reactions.

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Indications *Male:* Replacement therapy in testicular hormone deficiency states. Prevents atrophy of the accessory male sex organs following castration for as long as therapy is continued. Impotence and male climacteric symptoms when due to androgen deficiency. Primary eunuchoidism and eunuchism. Delayed puberty when established as not a simple familial trait. Indicated for those symptoms of panhypopituitarism related to hypogonadism, however, appropriate adrenal cortical and thyroid hormone replacement therapy remain of primary importance. *Female:* Palliation of androgen-responsive, advanced, inoperable breast cancer in women between 1 and 5 years postmenopausal or women in whom castration has shown the tumor to be hormone dependent. Prevention of postpartum breast manifestations of pain and engorgement; there is no satisfactory evidence that this drug prevents or suppresses lactation per se. In osteoporosis androgens may be of adjunctive value to adequate considerations of diet, calcium balance, physiotherapy and general health promoting measures. *Males and Females:* In the treatment of protein depletion states which occur in geriatric patients, in debilitation states, in chronic corticoid therapy, resistant fractures; cryptorchidism; creating a positive nitrogen balance, tissue repair and other anabolic effects. Androgenic steroids may produce a response in aplastic anemias, myelofibrosis, myelosclerosis, agnogenic myeloid metaplasia and hypoplastic anemias due to malignancy or myelotoxic drugs. Androgens are not of value in other anemias.
Contraindications Pregnancy (may virilize female fetus), mammary carcinoma in the male, prostatic carcinoma, severe liver disease, severe cardiorenal disease and severe persistent hypercalcemia.
Precautions Employ with caution in young boys to avoid precocious sexual development and premature epiphyseal closure. Androgens tend to promote retention of sodium and water, therefore, watch for edema—particularly in the elderly. Incidence and severity of edema have been minimal and have been associated only with high doses used for palliation of breast cancer. Hypercalcemia may occur, particularly in patients with metastatic breast carcinoma; if this occurs the drug should be discontinued. Changes in liver function tests, such as increased BSP retention and SGOT levels, can occur during therapy. Jaundice has been rarely reported. If liver function tests are altered, discontinue medication or reduce dose. Priapism is indicative of excessive dosage and is indication for temporary withdrawal of drug. When treating protein depletion states or osteoporosis, an adequate diet should be provided and prolonged immobilization avoided whenever possible. When treating aplastic or hypoplastic anemias, androgen therapy should not replace other measure such as transfusion, correction of iron deficiency, antibacterial therapy, and the use of corticosteroids.
Adverse reactions Nausea, dyspepsia, menstrual irregularities, hepatic dysfunction, priapism, edema, precocious sexual development, and premature epiphyseal closure in young patients have been reported. *Male*—Prolonged administration or excessive dose may cause inhibition of testicular function with oligospermia and decreased ejaculation volume. *Female*—Large doses or prolonged administration may produce masculinization with signs such as hirsutism, deepening of the voice, enlargement of the clitoris, acne, and sometimes, increased libido.
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ABSTRACTS, BOOK REVIEWS

TASTE AND SMELL IN VERTEBRATES

Ciba Foundation Symposium, edited by G.E.W. Wolstenholme and Julie Knight. J.&A. Churchill, London, 1970; 402 pages; 165 illustrations; $12.75.

This is the fifth and final symposium on another of the various senses by means of which the organism perceives events in its environment. After some preceding disappointments, it is pleasant to state that this opus was a joy to read. The usual score or so of experts had much to say—in clear and simple language.

First, taste was discussed. The reader was reminded that the seventh and ninth cranial nerves carry the afferents of this sense. Then, a series of very elegant experiments using the chorda tympani were presented. It is an anatomical quirk that carries the taste messages from the anterior portion of the tongue right past the ear drum. Utilizing this fact, surgeons were able to do elaborate studies on humans who needed operations on the stapes. The tongue taste buds could be stimulated by various acid, sour, bitter and sweet substances and the precise responses recorded. Most instructive!

Then, the olfactory epithelium was studied in minutest detail on the entire vertebrate orchestra. It is instructive (to me, at least) to learn that transduction occurs practically in the tips of the hairs of the specialized cells. The entire process is being studied now in biochemical detail. It appears very certain that major breakthroughs are just around the corner.

The hospital and school libraries will surely stock this monograph. Not only otolaryngologists but many non-experts—even as you and I—can benefit by scanning our way through this most superbly prepared and most readable book.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

SENSORINEURAL HEARING LOSS

Ciba Foundation Symposium. Edited by G.E.W. Wolstenholme and Julie Knight. J.&A. Churchill, 104 Gloucester Place, London; 358 pages with numerous tables and photomicrographs; 1970; $12.50.

Two score scientists from the most diverse areas of endeavor collaborated on this project. Besides the expected otologists, pathologists and biochemists, there were acrodynamic physicists, communication experts and other specialists almost too numerous to quote in extenso.

The result is so massively technical that yours truly scurried back to the elementary anatomy and physiology basic science volumes just in order to restore a recall of just what the learned folk were batting back and forth. I regret to report that the end product was almost a total disappointment. In this specific area there just has NOT been any sort of a fundamental break-through. Yes, we still know that sound is funnelled against the ear-drum; transmitted via the middle ear bones that impinge on the oval window. Then, the physical force sets up a wave in the endolymph and perilymph within the Organ of Corti where the hairs transmute the vibration, via the piezoelectric effect, into a

stimulus that travels up the cochlear nerve to the cortex.

Well! All this is almost ancient history. What is the underlying biochemical tale? We just don't (as yet) know. It may be heretical, but I would recommend to the reader Dolowitz on Basic Otolaryngology. (See my review in *JISMA*, March 1965, p. 261). Without being invidiously nasty, I can say in all candor that my rereading of Dolowitz told me more than this all too ponderous symposium.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

INFECTION CONTROL IN THE HOSPITAL

American Hospital Association, Chicago, Revised Edition, 1970.

Epidemiology and Infection Control in hospitals by virtue of the volume of patients, the ever-increasing multitude of antibiotics, and the wide variety of diagnostic and surgical procedures done has become increasingly complex. This revised, concise, yet broad scoped book will be very useful in organizing and maintaining an effective infection control program. It is well organized, easy to comprehend, and well supplemented with outlines and charts. For additional information a bibliography is provided at the end of each chapter. The index and table of contents are adequate and make specific subjects easy to find.

The value of the concept and the purpose of the book becomes apparent when one considers the health of the patient and the economic burden on the patient. As pointed out in the introduction, "if only 2% of the hospitalized patients develop an infection the hospital stay increases one day per patient at an annual cost of $48 million dollars."

Although of limited use to most physicians because of its special interest, the book fulfills the intent of providing guidelines to "Infection Control in the Hospital" and will be useful to persons interested in this problem.

ARTHUR C. JAY, M.D.
Muncie, Indiana

ONCOGENIC VIRUSES

2d ed. by Ludwik Gross. Pergamon Press, Elmsford, N.Y. 10523; 991 pages with 75 illustrations and 14 tables; 1970; $32.00.

Cancer is surely in the very forefront of the problems that are on their way of being resolved in this decade of the seventies. It is no accident that one of the foremost researchers in this burgeoning field of oncogenic viruses has come forth with a monograph that takes *no* back seat to anything written scientificially in any area whatsoever.

Out of his all but total knowledge of his subject, Dr. Gross has managed to compress into a single, most readable volume an explication of a topic that most would consider too erudite for anything less than a *many* volumed set. He is modest to the point of being retiring; he lists his authorities by alphabet at the end of each chapter; his own role is mentioned almost en passant!

It is impossible to do more than just glance at a few of his remarks. Thus, he quotes Pasteur as saying, in 1881, that the "microbe of hydrophobia must be a microorganism infinitesimally small." On p. 74 is an electron microscopic section (240,000 X) of the human wart virus. On p. 310, there are three photographs of workers in the field, one being Dr. Gross himself.

On p. 409, he launches into the crisp narration of the inhibiting effect of thymomectomy on virus-induced leukemia in mice—with many of the intriguing implications. He closes that chapter on p. 452 with the statement that "leukemias in mice induced with carcinogenic chemicals, hormones or radiation or occurring spontaneously are actually caused by transmissible, leukemogenic virus." An arresting concept! This is followed by no less than 20 *pages* of references!

In his closing chapter we come to his summary of Vertical and Horizontal transmission of oncogenic, pathogenic agents. The connection with the common communicable diseases is made very persuasively. He sums up, most tersely, in his final paragraph, by repeating his thesis: "The concept of viral etiology of tumors and leukemias. . . represents the most logical explanation of the origin of cancer and allied diseases in man."

All in all, I found this monograph hard to put down. I know that I've been instructed. What more can a reviewer say?

The errors in the text are trifling; the paper and binding are excellent. The author and Pergamon Press are to be congratulated for making so magnificent a volume available at such relatively low cost. But *Nobody* in Medicine, Biology or the allied disciplines can afford not to read this work.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

NEW ASPECTS OF THE STRUCTURE, FUNCTION AND BIOSYNTHESIS OF HEMOGLOBINS

T. Huisman & W. Schroeder, Chemical Rubber Co. Monoscience Series, 1971; 64 pages.

In 1910, Dr. J.B. Herrick first observed "freakish poikilocytosis" in a severely anemic Negro patient. This condition is now known as sickle cell anemia. In the ensuing decades, many other hemoglobin anomalies in red blood cells were uncovered in an ever-increasing number. Even 30 years ago, we were taught in physiology the difference in O_2 carrying capacity between oxidized and reduced hemoglobins. We all had to learn the tremendous difference made by just the tiniest p^H shifts.

Well, in this tiny volume, heavily illustrated to save words, we are now being brought up to date as to what actually goes on in the r.b.c.s and the Hb they carry. We see the graphic charts telling us just where the heme components are cradled; just how the ligands of Fe function; just what is meant by this or that alteration in the amino acid sequence.

It is most instructive, even if I cannot honestly say that I understood every word of what I read. It is even more sobering to realize how much is still to be discovered! Congratulations to the authors for making ever clearer the functions of ATP, DPG and IHP. The red blood cell is no longer an inert bit of organic matter. Its biomolecular nature is becoming ever more clarified. I really enjoyed perusing this monograph!

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New York, N.Y. 10029

Abstracts From Various Literature, Prepared by AMA

VALUE OF PREOPERATIVE OR POSTOPERATIVE TREATMENT BY RADIUM FOR CARCINOMA OF THE UTERINE BODY

J. Graham (Roswell Memorial Institute, Buffalo 14240)
Surg. Gynec. Obstet. 132:855-860 (May) 1971.

This is a report of the results in patients with stage I, group I tumors, in whom the preoperative or postoperative radiation treatment was randomly assigned. The five-year cure rate with hysterectomy alone was 64% or 21 of 33 patients, the vaginal recurrence rate was 12%, and the death rate from carcinoma was 12%.

Of the patients treated preoperatively with radium, the five-year cure rate was 76% or 45 of 59 patients, the vaginal recurrence rate was 3%, and the death rate from carcinoma was 14%. Of those receiving radium postoperatively, the five-year salvage rate was 81% or 25 of 31 patients, there were no recurrent tumors of the vagina, and 3% died from carcinoma. Hysterectomy followed by radium gives the best results.

EXCRETION OF GENTAMICIN VIA THE BRONCHIAL TREE

O. Wieser, H. Regula and W. Wundt (Fakultat fur Klinische Medizin Mannheim, Universitat Heidelberg, Heidelberg, West Germany)

Deutsch Med. Wschr. 96:870-872 (May 14) 1971.

Excretion of intramuscularly administered gentamicin via the tracheobronchial tree was measured in 50 patients. Secretions were obtained in 20 patients by aspiration during bronchoscopy, in 30 by spontaneous coughing up. Serial measurements indicated that gentamicin was demonstrable in effective bacteriostatic concentrations in the bronchopulmonary tract almost as long as in blood samples drawn simultaneously, an average of three hours.

CANCER IN JAPANESE EXPOSED AS CHILDREN TO ATOMIC BOMBS

S. Jablon et al. (Atomic Bomb Casualty Commission, Hiroshima)

Lancet 1:927-932 (May 8) 1971.

The incidence of cancer has been studied in a cohort of 20,609 people who were less than 10 years old at the time of the atomic bombs in Hiroshima and Nagasaki in 1945, including 15,584 exposed survivors and 5,025 unexposed controls. Among survivors who received 100 rads or more or whose radiation doses are unknown, no cancers were diagnosed before 1958. However, among the 1,109 high-dose survivors who were alive in January 1955, eight had died of leukemia by 1969 as compared with 0.42 such deaths expected, and eight more had died of cancer other than leukemia as compared with 1.1 expected. Both differences are highly significant statistically. Additionally, an excessive incidence of solid tumors was found for carcinoma of the thyroid (five cases compared with 2.2 expected) and other clinically diagnosed cancers (six observed, only 1.3 expected).

DE NOVO BRAIN TUMORS IN RENAL TRANSPLANT RECIPIENTS

S. A. Schneck (Univ of Colorado Medical Center, Denver 80220) and I. Penn

Lancet 1:983-986 (May 15) 1971.

Eleven of 24 mesenchymal neoplasms which have arisen de novo in patients with organ homografts throughout the world have involved the brain. In eight cases the tumors were present only in this organ. Nine neoplasms were reticulum cell sarcomas and two were unclassified lymphomas. These lesions appeared sooner after transplantation than did non-cerebral mesenchymal or epithelial tumors. The brain has no lymphatic system, and little proliferation of reactive cells takes place in response to foreign antigens unless prior immunization has occurred. Tumor cells could arise in the brain itself or be carried there from other sites. The poor immunological reactions of the unimmunized and immunosuppressed brain suggest the possibility that neoplastic cells would grow more readily in this relatively immunologically privileged environment than in other tissues.

PROGESTOGEN TREATMENT OF RECURRENT ENDOMETRIAL CARCINOMA

G. D. Malkasian, Jr., et al. (Mayo Clinic, Rochester, Minn. 55901)

Amer. J. Obstet. Gynec. 110:15-23 (May 1) 1971.

Experience with treatment of metastatic carcinoma of the endometrium with 17 α-hydroxyprogesterone caproate (Delalutin), 6-methyl-17 α-hydroxyprogesterone acetate (Depo-Provera) and 6,17-dimethyl-6-dehydroprogesterone (Colprone) revealed an objective response rate of 25%, 24% and 23%, respectively. Side effects were minimal. Patients who appeared to attain the best objective remissions were those who had recurrences three years or more after initial therapy, those who had low-grade lesions and those who had pulmonary metastases.

HOSPITAL SANITATION: MASSIVE BACTERIAL CONTAMINATION OF WET MOP

J. C. N. Westwood (Ottawa General Hosp., Ottawa), M. A. Miehell and S. Legace

Appl. Microbiol. 21:693-697 (April) 1971.

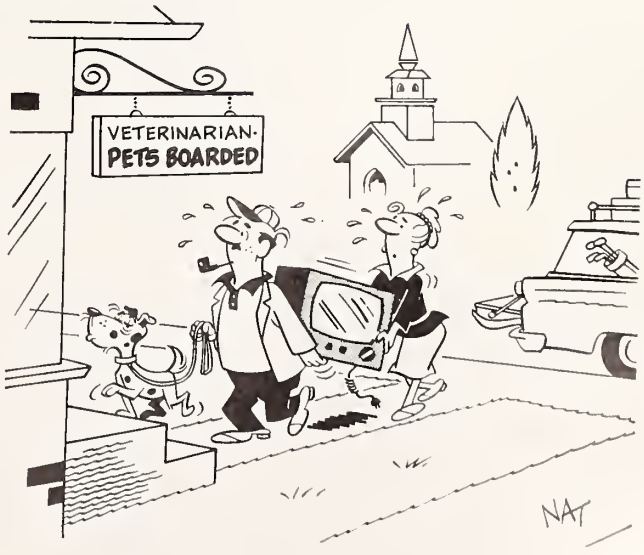
Following the demonstration of massive spread of bacterial contamination throughout the hospital by the wet-mopping technique in use, quantitative studies were undertaken to determine the source of contamination and to institute measures of control. Mops, stored-wet, supported bacterial growth to very high levels and could not be adequately decontaminated by chemical disinfection. Laundering and adequate drying provided effective decontamination but build-up of bacterial counts occurred if mops were not changed daily or if disinfectant was omitted from the washwater.

ANGIOGRAPHY IN INVESTIGATION OF ISCHEMIC EPISODES IN TERRITORY OF INTERNAL CAROTID ARTERY

J. Marshall (National Hosp., London)

Lancet 1:719-721 (April 10) 1971.

In a series of 104 consecutive cases of ischemic episodes in the territory of the internal carotid artery, 82 patients were subjected to angiography which proved abnormal in 41. Endarterectomy was not possible in 25 but was carried out successfully in the remaining 16 patients. There were no permanent complications from angiography.



EXPERIMENTAL WITHDRAWAL OF LITHIUM IN RECOVERED MANIC-DEPRESSIVE PATIENTS: REPORT OF FIVE CASES

J. G. Small (Indiana Univ. School of Medicine, Indianapolis 46202), I. F. Small and D. F. Moore

Amer. J. Psychiat 127:1555-1558 (May) 1971.

The authors conducted a single-blind study to determine whether patients with manic-depressive disease who responded favorably to lithium would show significant change when placebo was substituted. Symptoms recurred in all subjects within six weeks of placebo substitution, and clinical stability returned when lithium treatment was resumed. These findings are discussed in relation to the question of the prophylactic influence of long-term maintenance on lithium.

INSULIN AND GLUCOSE TO REDUCE CATABOLIC RESPONSE TO INJURY IN BURNED PATIENTS

P. Hinton et al. (S. P. Allison Bristol Royal Infirmary, Bristol, England)

Lancet 1:767-769 (April 17) 1971.

The effect of high doses of insulin (200 to 600 units daily) with 50% glucose in water infusion to maintain normoglycemia is described. This treatment reduced the nitrogen and potassium losses of severely burned patients to low values which could easily be replaced by a normal diet.

SAFETY OF LAP BELT RESTRAINT FOR PREGNANT VICTIMS OF AUTOMOBILE COLLISIONS

W. M. Crosby and J. P. Costiloe (800 NE 13th St., Oklahoma City 73100)

New Eng. J. Med. 284:632-635 (March 25) 1971.

A study was made of 441 pregnant victims of automobile accidents, 69 of whom were lap-belted and 372 unrestrained. Lap belt restraint was associated with a reduction in maternal death from 7.8% to 3.6% and with an increase in fetal loss from 14.4% to 16.7% in severe collisions. Because these differences are not statistically significant, it is concluded that a lap belt restraint is not harmful to either the mother or the fetus. Lap belt restraint is effective in reducing injury primarily by preventing ejection. Among those involved in severe collisions, the maternal death rate among ejectees was 33% and 5% among those not ejected. The fetal death rate was 47% when the mother was ejected and 11% when she was not. Since these differences are statistically significant, lap belt restraint should be recommended for use by pregnant travelers.

EFFECT OF ASPIRIN, SODIUM SALICYLATE, AND ACETAMINOPHEN ON BLEEDING

A. H. Sutor (Mayo Graduate School of Medicine, Rochester, Minn. 55901), E. J. W. Bowie, and C. A. Owen

Mayo Clin. Proc. 46:178-181 (March) 1971.

The effect of aspirin, sodium salicylate, and acetaminophen on hemostasis was tested by a new quantitative, semi-automated technique which measures the time, pattern, and intensity of bleeding from skin punctures. Sodium salicylate and acetaminophen did not alter hemostasis in the majority of normal subjects. However, oral administration of 650 mg of aspirin interfered with normal hemostasis within 70 minutes after ingestion. Half of the subjects tested showed a significant increase in bleeding time after aspirin, and three fourths lost at least four times as much blood. ◄

Pre-Sate® (chlorphentermine hydrochloride)

Caution: Federal law prohibits dispensing without prescription.

Indications
Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (i.e. several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.

Contraindications
Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.

Warnings
When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.
Drug Dependence Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with the high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.
Usage In Pregnancy The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.
Usage In Children Not recommended for use in children under 12 years of age.

Precautions
In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorectic agent and a restrictive dietary regimen.

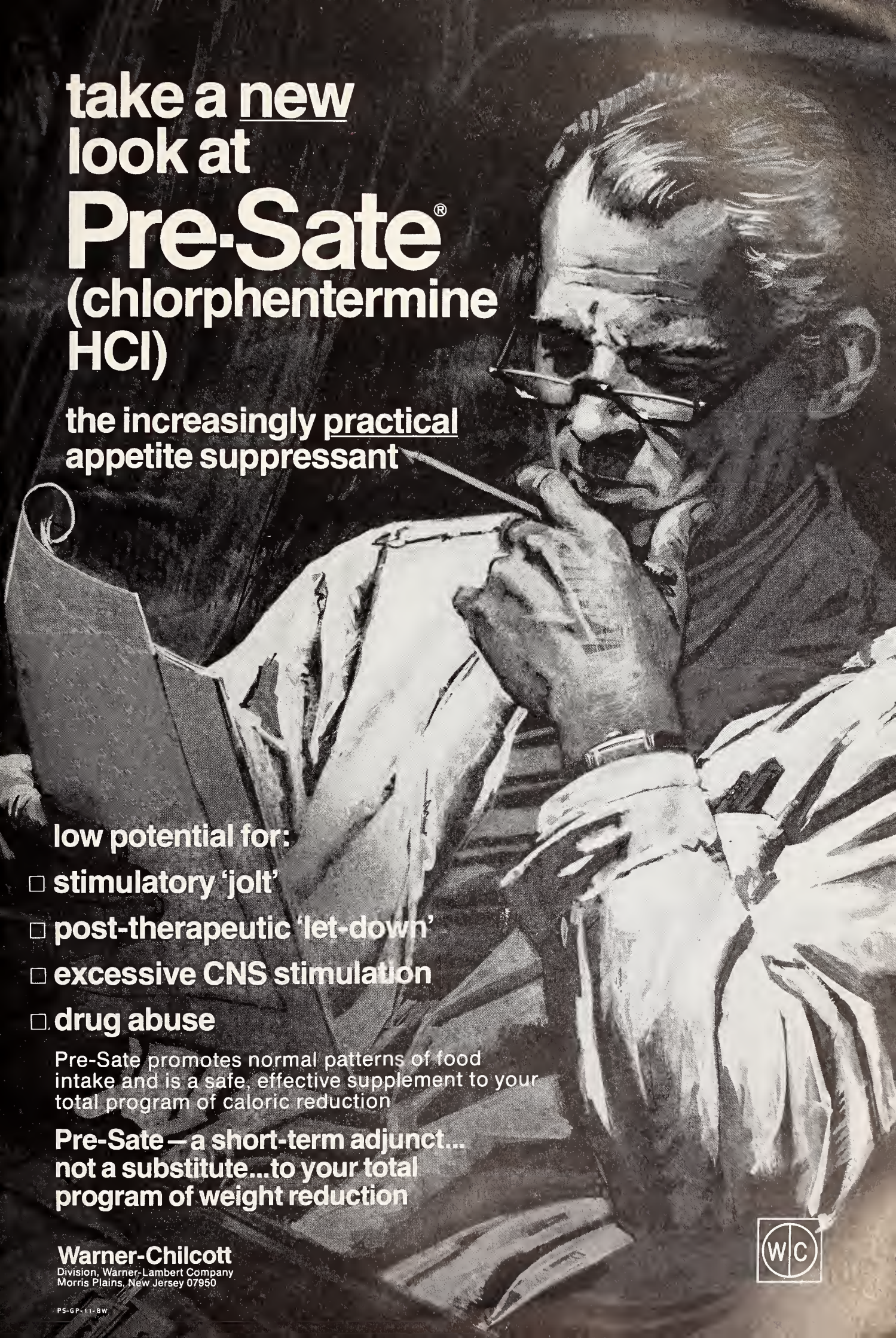
Adverse Reactions
Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.

Dosage and Administration
The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.

Overdosage
Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.
Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

How Supplied
Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.

Full information is available on request.


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Pre-Sate®
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Utilization Review by Blue Shield Guards Against Unwarranted Claims

Utilization Review, a program designed to insure Blue Shield members highest quality medical care at the lowest possible cost, constantly attempts to improve its service through the detection, prevention and elimination of errors and abuses that can result in unwarranted claims payments.

The system utilizes a series of sophisticated computer generated reports which collect, assemble and sort data base information from claim statistics. These reports summarize and objectively interpret patterns of practice related to a specific peer group. Of basic concern is the appropriateness and normality of practice patterns.

This appropriateness is based on a comparison with what would normally be expected of other physicians in the same locality with similar specialties. The comparability is derived statistically, and those patterns that are determined to be "abnormal" are manually reviewed by a subjective examination of selected claim history.

Objectives of the Blue Shield Utilization Review program are: promotion of effective use of health care service, conservation of health care dollars, equity among providers and the consuming public, and service to the medical profession which is actively concerned with problems associated with ineffective utilization.

The claims review system includes four phases:

1, Detection; 2, Investigation and analysis of data; 3, Disposition; 4, Education.

The detection phase is concerned with discovery and recognition of possible errors or abuses which could result in unwarranted claim payments, involving either payments for possible unnecessary medical services or for services reported but never rendered.

The system was designed to accomplish three main objectives: 1, To provide a means of detecting those who may be possibly overutilizing the program; 2, To provide adequate reference statistics to support suspicion; 3, To provide a means of detecting overutilization by a member.

The system uses as a case detection method the comparison of the practice of a physician to the practice of other physicians in the same peer group in an effort to isolate abnormal practice patterns.



JOHN P. Flanagan (left), director of the Blue Shield Utilization Review program, and Dr. Glen V. Ryan, Blue Shield medical advisor who is a former chairman of the Board of Directors, review a claim.

Determination of that point at which a ratio is abnormal is accomplished by the following:

1. Grouping all the ratios for a type of service and procedure in ascending sequence by peer group; and

2. Computing the average ratio and adding one or more standard deviations creating a "norm."

An important aim of the system is to provide an analysis of each procedure performed for the current base period, statewide, to see if the norm was exceeded by anyone. All details of a practice are researched, and if a norm has been exceeded, the information will appear on a microfilm report showing all the details for the base period.

If further study is needed, an effort is made to collect all available facts concerning the case. Hospital records, physician's office records, patient interviews and questionnaires are employed. These external sources of information are gathered together with available internal information from statistical profiles of claims experience.

Should there be a possibility of error or abuse, the problem is channeled to Blue Shield medical advisors. If advisors have reason to question the case, a letter is sent to the physician informing him of the problem and requesting clarification. Also, when necessary, research is conducted by Blue Shield Professional Relations personnel.

In the event misutilization, abuse or fraud is evident, the situation is referred to the Blue Shield executive committee, composed of seven practicing physicians, the County Medical Society and the State Medical Association for review, recommendation or action. Cases involving outright fraud after a review by legal counsel may be referred to the District Attorney's office.

In instances where the member is responsible for misuse of his Blue Shield coverage, personal meetings are arranged with the member or his employer. When it is evident an employee has created a utilization problem resulting in adverse financial experience, the employer will be asked to take corrective action. In the event the member is involved in fraud, the case will be referred to legal counsel for presentation to the District Attorney.

The professional relations staff of Blue Shield seeks to educate the professional community as to the objectives of the utilization program and its usefulness, through these three phases:

Orientation and discussion of the utilization program at hospital medical staff meetings.

Outlining the program with the Blue Shield District Advisory Council at the various district meetings.

An in-depth discussion of the program at the Blue Shield Advisory Council Seminar in Indianapolis.

Dr. Glen V. Ryan, Medical Advisor and Past Chairman of the Blue Shield Board of Directors, points out that "Utilization review activities are expected to provide a bonus effect in both the cost and quality of medical care by reason of a deterrent factor which will become greater as physicians and the public become aware of its capabilities."

This awareness is becoming greater as utilization review personnel are becoming more skilled and experienced in the techniques of detection, investigation and prevention of abusive practices. ◄

DISEASE PREVENTION by Immunization and Chemoprophylaxis*

Disease	*Agent Used*	*Recommended For*	*Method of Administration*	*Type of Immunity*	*Duration of Protection*	*Booster Injection*
Cholera	Cholera Vaccine	Travelers vaccinated in the United States require only one dose of cholera vaccine (dose number one in table at right) and should receive the second dose only if they will be traveling or working in areas where cholera is epidemic or endemic and sanitation is less than adequate.	Dose Number / Age (years) Under 5 / 5-10 / Over 10 1 — 0.1 ml — 0.3 ml — 0.5 ml 2 — 0.3 ml — 0.5 ml — 1.0 ml	Active	6 months	Should be given every six months as long as likelihood of exposure exists. Same volume as dose number two of primary series.
Diphtheria	Diphtheria Antitoxin	All early cases	Intravenous preferred. Warning: Test for sensitivity to horse serum. Dosage dependent on degree of toxicity rather than age and weight. 20,000 units to 120,000 units.	Passive	Short	Additional antitoxin given dependent upon illness and toxicity.
Diphtheria	Diphtheria toxoid (alum precipitated or aluminun phosphate adsorbed, for adult use, 2 Lf of antigen).	Children older than 6 years and adults. Use only when there are definite contraindications to other components of combined antigen.	Two intramusuclar injections of 0.5 cc. each, four to six weeks apart and third dose one year later.	Active	Indefinite	0.5 cc. every 10 years.
Diphtheria	Diphtheria-Pertussis-Tetanus alum precipitated or aluminum hydroxide (or aluminum phosphate) adsorbed diphtheria and tetanus toxoids; containing 12 protective antigenic units of vaccine per 1.5 cc. (DPT)	Children two months through six years.	(1) First dose of 0.5 cc. deep intramuscularly —follow injection with 0.1-0.2 cc. air. Given 2-3 months age. (2) Second dose of 0.5 cc. deep intramuscularly one month after first dose. (3) Third dose of 0.5 cc. deep intramuscularly one month after 2nd dose. (4) Reinforcing dose one year after third dose.	Active	Indefinite	D. P. T. booster of 0.5 cc. at 3-6 years. (Preferably at time of school entrance—kindergarten or elementary school.)

Diphtheria	Diphtheria Tetanus Toxoid alum precipitated or aluminum hydroxide (or aluminum phosphate) adsorbed. (For adult use, Td, 2Lf of diphtheria toxoid)	Children over 6 years and adults	Primary immunization. (1) First dose of 0.5 cc. IM or subcu (2) Second dose of 0.5 cc. IM or subcu 4-6 weeks later. (3) Reinforcing dose one year after (2)	Active	Indefinite	Diphtheria Tetanus (Td) booster every 10 years.
Hepatitis, Infectious (Epidemic)	Immune Serum Globulin (Gamma Globulin)	All exposed in household, institution, etc.	Dosage: 0.01 cc. per pound of body weight. Given intramuscularly.	Passive	Brief	Repeat each exposure.
Influenza	Polyvalent Vaccine (Subject to annual changes in recommendations late summer or fall)	Use during epidemics		Active (in 70% + immunized)	Short: 3-4 months	Repeat primary injection and/or injections annually.
		Children	Give total of 1.0 cc. in the course of one week.			
		Adults—especially all with chronic debilitating disease of heart and lungs.	1.0 cc. subcutaneously. *Warning:* Precautions must be taken in individuals sensitive to egg protein. *(Note:* There is less chance of local or systemic reaction if only 0.1 cc. is given intradermally for a total of 2 doses 7-10 days apart).			
Measles	(1) Live, Attenuated Vaccine (with or without Measles Immune Globulin) (2) Live, "Further Attenuated" Vaccine	12 months and older	Single dose subcutaneously	Active	Greater than seven years. May be lifelong.	None
Mumps	Mumps Virus Vaccine, Live, Attenuated	Children 12 months or older Adults who have not had mumps	One dose subcutaneously	Active	Three years known—probably much longer	Not known at present
Meningococcic Meningitis	Sulfadiazine (When epidemic strain is sulfonamide sensitive.)	Control of exposed persons in community groups Children up to 11 yrs.	0.5 m. twice daily for 2 days.	None Chemical prophylaxis only	Very brief—for one exposure only.	Repeat following each exposure.
		Adults (and children 12 yrs. or over)	1.0 gm. twice daily for 2 days.			
Pertussis	Pertussis Vaccine saline suspended (See Double and Triple antigens under "Diphtheria")	Children during epidemic	A total of 12 N. I. H. units divided into 3 equal doses of 4 N. I. H. units (0.5 cc.) given subcutaneously at intervals of one week.	Active	Indefinite	1 year after primary series, 2 years after primary series and then every three years to 6 or 7 years of age.

Disease	Agent Used	Recommended For	Method of Administration	Type of Immunity	Duration of Protection	Booster Injection
Pertussis	Pertussis Vaccine alum precipitated or aluminum hydroxide adsorbed (See Double and Triple antigens under "Diphtheria")	Routine immunization of infants when DPT is contraindicated	A total of 12 N. I. H. units divided into 3 equal doses of 4 N. I. H. units each (0.5 cc.) injected intramuscularly at intervals of 4 to 6 weeks.	Active	Indefinite	18 months—3-4 years. 6-7 years usually given as DPT.
		Exposure Recall		Active	Indefinite	.4 NIH units (0.5 cc.) saline suspension subcutaneously if child has not had immunization past 2 years.
Plague	Plague Vaccine—a suspension of 2000 million killed Pasteurella per milliliter	Epidemics and areas with high endemic rate.	Dose No. / Age (years): Under 1 year: 1: 0.1 ml; 2: 0.1 ml; 3: 0.04 ml. 1-4: 1: 0.2 ml; 2: 0.2 ml; 3: 0.08 ml. 5-10: 1: 0.3 ml; 2: 0.3 ml; 3: 0.12 ml. Over 10: 1: 0.5 ml; 2: 0.5 ml; 3: 0.2 ml	Active	Partial protection for period of 4-6 mos.	Every 6-12 months as long as risk of exposure persists. Same volume as third dose of primary series.
Poliomyelitis*	Poliomyelitis (Salk) Vaccine	All Ages	Four parenteral doses; three at 1 month intervals; fourth 6-12 mo. after #3	Active	Not known (Salk has demonstrated adequate antibodies present after 8 years)	1 cc every 2-3 years Need for boosters obviated by full course of Oral Polio Vaccine
	Poliomyelitis trivalent oral (Sabin)	Infants Children Adults	First dose 6-12 weeks, 2nd dose 8 weeks later 3rd dose 8-12 months after 2nd. Children, two doses 6-8 wks apart; third dose 8-12 months after second. Not necessary in U.S. but if at risk may be immunized as are children.	Active	Thought to be permanent	1 dose trivalent on entering school.
Rabies	Rabies—hyperimmune serum 1000 units per 40 pounds of body weight Rabies Vaccine 14-21 doses	Licks of abraded skin or mucosa by proven rabid, suspicious, escaped, killed or unknown animal	Hyperimmune serum within 24-72 hours of exposure. Follow within 24 hours with Rabies Vaccine.	Passive immunity from hyperimmune serum	Few weeks	Repeat initial dose hyperimmune serum, but not after beginning Rabies Vaccine series as serum will block antibody production. Booster 10th and 20th day after last dose vaccine.
		Bites of healthy animal, multiple, or face or head bites	Hyperimmune serum. Start vaccine but stop if animal remains normal for 5 days.	Active immunity from Rabies Vaccine	Indefinite	If full course is completed, give booster 10th and 20th day after last dose vaccine.

Rabies		Bite of healthy animal, other than head or neck	No treatment. If animal becomes suspicious during 14 days observation give serum and vaccine at first suspicious signs.			Booster 10th and 20th day after last dose vaccine.
		Bites—animal rabid, escaped, killed, unknown or any bites by any wild animal	Start treatment immediately, using hyperimmune serum followed by 14-21 doses vaccine, depending upon whether single or multiple bites and location.			Booster 10th and 20th day after last dose vaccine.
		Bat bites and exposure to bats	Hyperimmune serum, then start treatment with Rabies Vaccine immediately without waiting for laboratory report. Bats are only animals known to occasionally survive rabies and remain carriers.			Booster 10th and 20th day after last dose vaccine.
Rubella	Live virus vaccine	All children ages 1-12 yrs.	1 dose subcutaneously	Active	At least 3 yrs—Long term protection likely	Not known
Rocky Mountain Spotted Fever	Rocky Mountain Spotted Fever Vaccine	Not routinely recommended since advent of specific antibiotic therapy. May be used in areas of high incidence among persons of high risk.	Adults: 3 injections each 1.0 cc. subcutaneously or intramuscularly at intervals of one week. Children—under 10 years three injections each 0.5 cc. subcutaneously or intramuscularly at intervals of one week.	Active	One year	1.0 cc. booster annually
Smallpox	Smallpox Vaccine (Vaccinia virus)	Children and adults	Between one and two years of age or at any age under conditions of exposure or foreign travel.	Active	Indefinite, average 3 years	School entrance—Kindergarten or elementary school. Potential exposure—at 3 year intervals for those who might be exposed by travel to endemic areas or for those such as hospital personnel at risk of exposure to infection newly introduced into the United States. Routine—at 10 years interval
Tetanus	Tetanus Immune Globulin (Human) (TIG)	Unimmunized persons, especially those with crushing injuries, burns, or penetrating wounds; also, for persons seen more than 24 hours after tetanus-prone injury who have had no tetanus toxoid for many years.	Adults: 250 units IM for wounds of average severity, up to 500 units for very severe wounds; children: 4 units per kilogram body weight.	Passive	21 days	Must repeat with each injury. Immunization with tetanus toxoid obviates need for further TIG.

Disease	Agent Used	Recommended For	Method of Administration	Type of Immunity	Duration of Protection	Booster Injection
Tetanus	Tetanus Antitoxin Use only if Tetanus Immune Globulin (Human) is unavailable.	All cases of puncture wounds and animal bites when person has not been immunized or more than 5 years since last booster.	Caution: Skin test first for serum sensitivity. Intramuscular injection of 3000-10,000 units anti-toxin.	Passive	10 days	Repeat with each injury. Because of hazard to horse serum active immunization with toxoid preferred.
Tetanus	Tetanus Toxoid, depot (alum precipitated or adsorbed) (See Double and Triple antigens under "Diphtheria")	Hypersensitivity to other components of DTP and Td.	Two doses, each 0.5 cc. given intramuscularly, not less than four weeks apart followed a reinforcing injection 8-12 months later.	Active	Extremely long lasting	Every 10 years
Typhoid Fever	Typhoid Vaccine	Exposure to a carrier in a household; outbreaks of typhoid fever in a community; travel to areas where typhoid fever is endemic.	Adults and children over 10 years old: 0.5 ml subcutaneously on two occasions, separated by 4 or more weeks. Children less than 10 years old: 0.25 ml subcutaneously on two occasions, separated by 4 or more weeks. If more rapid immunization is required, 3 doses of the same volume listed above may be given at weekly intervals but this schedule may be less effective.	Active	Indefinite — at least 3 yrs.	Every one to three years under conditions of continued or repeated exposure. Adults and children over 10 years old: 0.5 ml subcutaneously or 0.1 ml intradermally. Children 6 mo. to 10 yrs: 0.25 ml subcutaneously or 0.1 ml intradermally
Typhus Fever	Typhus Fever Vaccine	Not required for travellers to any part of the world. Suggested for persons living or working in close contact with certain indigenous populations in remote areas of South America, Africa and Asia.	Adults Two doses, each 0.5 cc. at intervals of 4 or more weeks given subcutaneously. Allergy to egg or chicken protein only contraindication. Children under 10 years: one half of adult dose.	Active	Relative 6-12 months as long as opportunity for exposure exists	Adults Routine every 6-12 months or whenever threat of outbreak occurs. Same dose as in initial series.
Yellow Fever	Yellow Fever Vaccine* (Obtainable only at U. S. P. H. S. Hospital or Yellow Fever Immunization Depots. See footnote where obtainable in Indiana.)	All persons traveling in or through or living in endemic areas. Should receive vaccine 10 days before arrival in area.	One dose 0.5 cc. of a 1:10 dilution of concentrated vaccine, freshly prepared. Given subcutaneously. Should not be given to person ill with virus disease or at same time cowpox virus is given. Children's dose—same as adult.	Active	Every 10 years	Every 10 years repeat immunization.

* While many contraindications are listed for various biologicals it should be recognized that in the interest of brevity it was impossible to give all details. In case of doubt consult standard reference for detailed description of biological in question and/or pharmaceutical company's circular accompanying original package of biological.

All of the biologicals listed may be obtained through normal supply channels with the exception of Yellow Fever Vaccine. Because of hazards if yellow fever vaccine is improperly handled it can only be obtained from U. S. P. H. S. depots. In Indiana these depots are:

Fort Wayne
Board of Public Health
337 East Wayne St. 46802
Ph. 219—742-9302
Wednesday 11:00 a.m. - 12:00 noon
Fee: Yes

Indianapolis
Indiana University
1100 West Michigan St. 46202
Ph. 317—639-8123
Friday, a.m.
Fee: Yes

Elkhart
County Health Unit
313 N. Second St. 46514
Ph. 219—294-2225
First & 3rd Wednesday 2 p.m.
Fee: Yes

Physicians having patients requiring yellow fever immunization should advise person to call or write the above, as inoculations are given by appointment only on one day a week. There is a fee to cover vaccine and administration.
(Revised)

Division of Communicable Disease Control
Indiana State Board of Health ◄

New Members, Additions to Roster

New members of the Indiana State Medical Association since the publication of the Roster in the June issue of *The Journal* are:

CLARK COUNTY

Ofray-Crispulo M. Rivera, M.D.
719 E. Delaware Court
Sellersburg 47172 (Resident)

GRANT COUNTY

Frenita Bernal Guevara, M.D.
Marion General Hospital
Marion 46952 (GP)

Tierry Garcia, M.D.
131 N. Washington Street
Marion 46952 (GP)

JOHNSON COUNTY

Anthony Gannon, M.D.
251 East Jefferson
Franklin 46131 (GP)

LAKE COUNTY

Domenico J. Deschamps, M.D.
3290 Grant St.
Gary 46408 (GP)

MARION COUNTY

Ronald Blankenbaker, M.D.
5207 Washington Blvd.
Indianapolis 46220 (Resident)

Marvin Eugene Eastlund, M.D.
7661 Harcourt Road
Indianapolis 46260 (Resident)

Timothy Alan Habbe, M.D.
2135 North Cole
Speedway 46224 (Resident)

Nina C. King, M.D.
1769 Beeler Ave.
Indianapolis 46224 (Resident)

Mary Ann Mentendiek, M.D.
141 Buckingham Drive
Indianapolis 46208 (Resident)

Roberto L. Olivares, Jr., M.D.
7575 E. 52nd Street
Indianapolis 46226 (Resident)

George J. Quigley, M.D.
7510 N. Audubon Road
Indianapolis 46250 (Resident)

Juan C. Bolivar, M.D.
1481 W. 10th Street
Vet. Admn. Hospital
Indianapolis 46202 (GS)

Norman D. Gardner, M.D.
3266 North Meridian Street
Indianapolis 46208 (R)

ST. JOSEPH COUNTY

Luis N. Galup, M.D.
531 North Main Street
South Bend 46601

TIPPECANOE COUNTY

Alan A. Alexander, M.D.
2600 Greenbush Street
Lafayette 47904 (PD)

John W. Remo, M.D.
2600 Greenbush Street
Lafayette 47904 (R)

John C. Scanlon, M.D.
2600 Greenbush Street
Lafayette 47904 (IM)

VANDERBURGH COUNTY

James E. Palen, M.D.
1401 S. Green River Road
Evansville 47715 (GP)

WASHINGTON COUNTY

Flor T. Castueras, M.D.
906 W. Mulberry
Salem 47167

WHITE COUNTY

Gerald R. Bougher, M.D.
R. R. 1,
Monticello 47960 (GP)

In addition, names of the following full-dues-paying members were omitted from the June 1971 Roster. *The Journal* regrets any embarrassment or inconvenience caused by the error.

Bolander, James Edwin, M.D. (Allen), 3217 Lake Ave., Fort Wayne 46805 (GP)

Connelly, Jerry, M.D. (Allen) 3217 Lake Ave., Fort Wayne 46805 (GP)

Franke, Gordon Raymond, M.D. (Allen) 3010 E. State Blvd., Fort Wayne 46805 (GP)

Haller, Richard Carl, M.D. (Allen) 3124 E. State Blvd., Fort Wayne 46805 (N)

Juergens, Richard Bowman, M.D. (Allen) 1724 Prairie Lane, Fort Wayne 46808 (GP)

Keck, Carleton Allen, M.D., (Allen) 2902 Fairfield Ave., Fort Wayne 46807 (OPH)

Kidder, Orva Thurl, M.D. (Allen) Irene Byron Hospital, Fort Wayne 46808 (PUD)

Klooze, Kenneth Ward, M.D. (Allen) 3610 Brooklyn Ave., Fort Wayne 46807 (GP)

Mensch, James, M.D. (Allen) 2120 Forest Park Blvd., Fort Wayne 46808 (Anes)

Munoz, Jose Cui, M.D. (Allen) 3030 Lake Ave., Fort Wayne 46805 (PD)

Perry, Frederic Ginther, M.D. (Allen) 2902 Fairfield Ave., Fort Wayne 46807 (D)

Safirstein, Roszerman, M., M.D. (Allen) 2330 Beacon St., Fort Wayne 46808 (Anes)

David, Delfin P., M.D. (Dearborn-Ohio), 226 Main St., Rising Sun 47040 (GP)

Watson, Leo G., M.D., (Howard) 3433 S. Lafountain, Kokomo 46901 (OPH)

Bate, Mostafa H., M.D., (Marion) 5202 N. Illinois St., Indianapolis 46208 (GS)

Dowd, Joseph A., M.D., (Marion) Butler University Health Center, 525 W. Hampton Drive, Indianapolis 46208 (IM)

McCarthy, Joseph C., M.D. (Vanderburgh) 715 First Ave., Evansville 47710 (GP) ◄

Two New Booklets Available From American Heart Ass'n

A new booklet intended to assure patient and personnel safety in performing cardiac catheterization as well as to promote maximal diagnostic accuracy, obviate unnecessary procedures and minimize the need for repetition, has been published by the Heart Association.

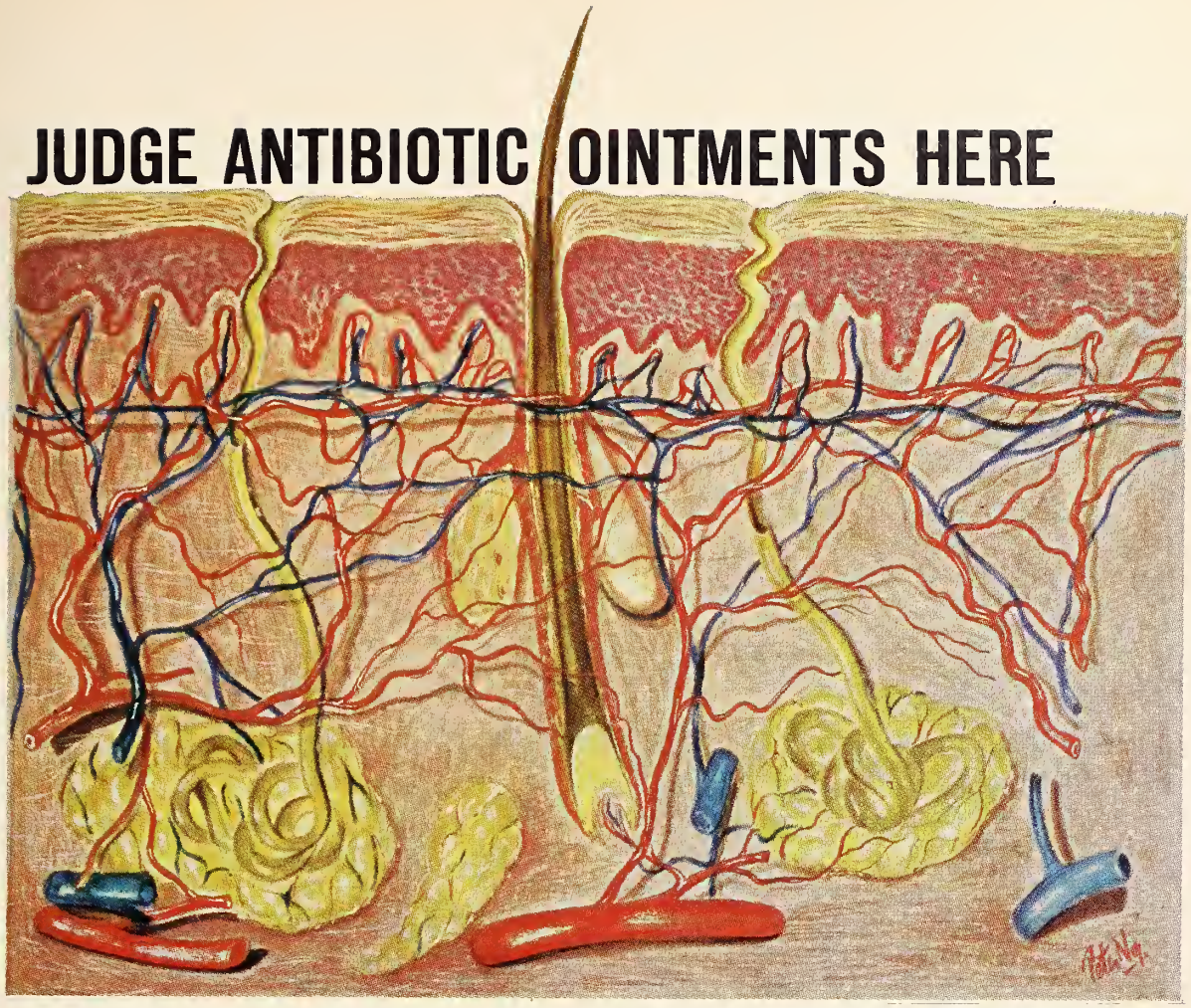
Entitled "Standards for a Cardiac Catheterization Laboratory—A Guide for Cardiologists and for Institutions Sponsoring Cardiac Catheterization Laboratories," the report was prepared by the Association's Council on Rheumatic Fever and Congenital Heart Disease and Council on Clinical Cardiology. The first AHA statement of standards for catheterization laboratories, it covers personnel, equipment, radiation protection, procedures and case load.

Updated information on the uses of anticoagulant drugs is contained in a completely revised and redesigned edition of the American Heart Association booklet, "A Guide to Anticoagulant Therapy," now available to physicians, hospitals and medical schools.

The publication furnishes guiding principles and practical recommendations in the uses of anticoagulants as aids in preventing thrombosis or embolism, including the latest findings on the clotting mechanism, where in that mechanism anticoagulants work and compatibilities and incompatibilities of other drugs with anticoagulants.

Copies of the revised booklets may be ordered through local Heart groups or the AHA National Office, 44 E. 23rd St., New York 10010.

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

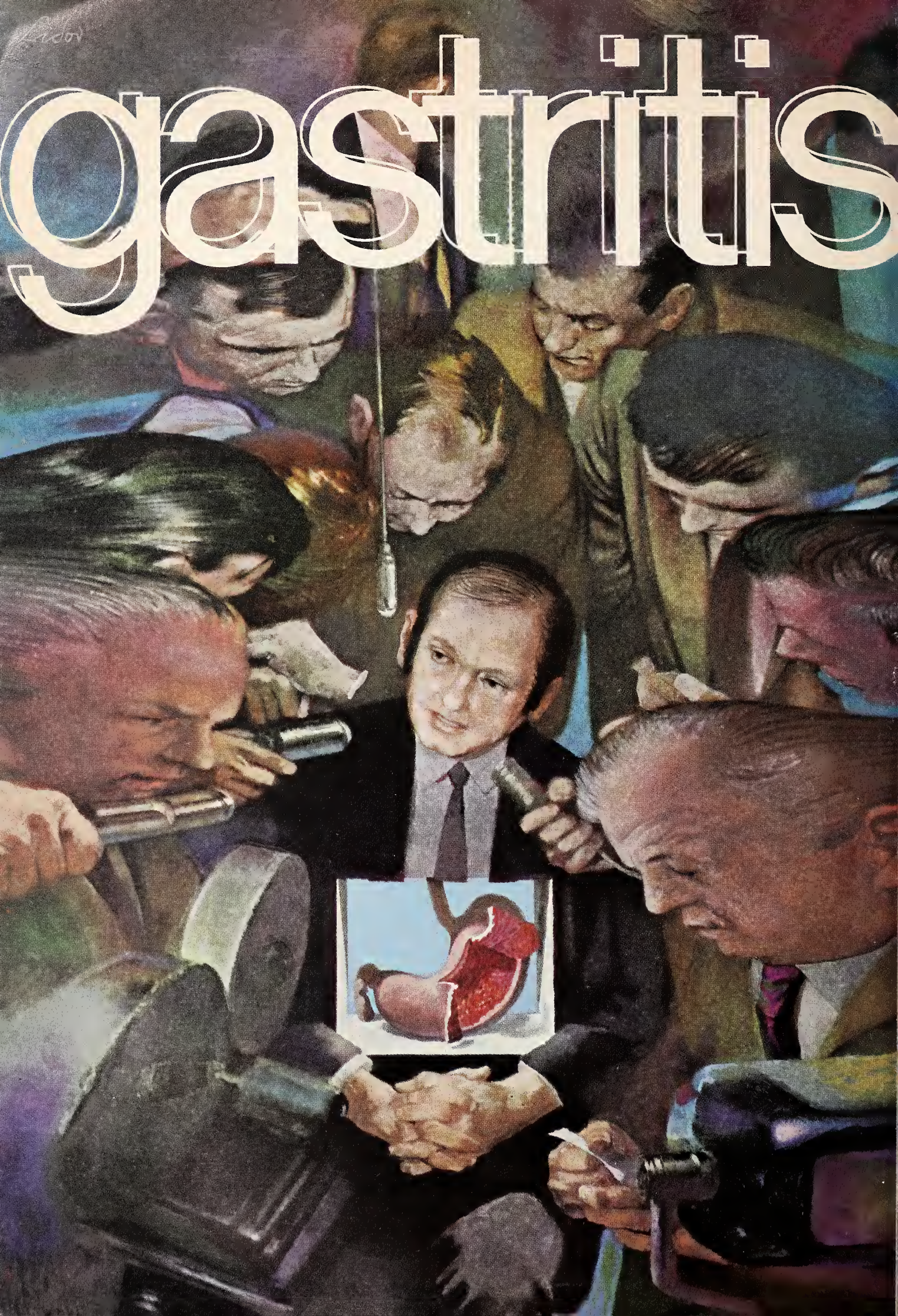
'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

gastritis



when G-I symptoms demand a potent synthetic anticholinergic

move up to "the Robinul response"

In treating hypersecretion and hypermotility associated with gastritis are you disappointed in the results you've been getting with some of the synthetics? Then *move up* to a potent anticholinergic—Robinul® Forte (2 mg. glycopyrrolate). It provides prompt, pronounced, prolonged suppression of gastric hypersecretion, making it a highly effective agent in gastritis and other upper G-I conditions associated with hypersecretion and hypermotility. Because Robinul Forte exerts a profound antispasmodic action, it is also useful in the treatment of lower G-I disorders, such as functional bowel distress and spastic and irritable colon. If the patient has a "one tract mind" concerning his condition, you can help control the anxiety and tenseness by prescribing Robinul®-PH Forte (2 mg. glycopyrrolate with 16.2 mg. phenobarbital —warning: may be habit forming).

Robinul® 2mg. Forte (glycopyrrolate)

INDICATIONS Robinul Forte (glycopyrrolate, 2 mg.) and Robinul-PH Forte are double-strength dosage forms of glycopyrrolate. They are primarily ndicated for patients who are less responsive to anticholinergic therapy and for control of the more prominent symptomatology associated with cute episodes of gastrointestinal disorders. Emphasis should be on total management, with due consideration of the various therapeutic modalities vailable, including diet, antacids, anticholinergic agents, sedatives, and attention to emotional problems. Accordingly, glycopyrrolate is recom-ended in the management of gastrointestinal disorders amenable to anticholinergic therapy, such as: (1) duodenal ulcer, duodenitis, pylorospasm; ?) gastric ulcer, gastritis, esophageal hiatal hernia, hyperchlorhydria, pyrosis, aerophagia, gastroenteritis; (3) esophagitis; (4) cholecystitis, chronic ancreatitis; (5) spastic and irritable colon, ulcerative colitis, functional bowel distress, diverticulitis, acute enteritis, diarrhea; and (6) splenic flexure ndrome, neurogenic gastrointestinal disturbances. When these conditions are associated with psychic overlay, the formulation with phenobarbital ay be indicated. ■ CONTRAINDICATIONS Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric reten-n, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH rte (glycopyrrolate with phenobarbital), sensitivity to phenobarbital. ■ PRECAUTIONS Administer with caution in the presence of incipient laucoma. ■ SIDE EFFECTS The most frequent side effect noted during clinical trials was dry mouth. Thirty-three (3.3%) of 1,009 patients receiving to 32 mg. of glycopyrrolate a day complained of dry mouth of moderate to severe degree, but only 11 discontinued treatment because of this. lurred vision, constipation, and urinary hesitancy have been reported infrequently. Other side effects associated with the use of anticholinergic rugs include: tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsi-ess, and rash. ■ DOSAGE The average and maximum recommended dose of Robinul Forte (glycopyrrolate, 2 mg.) or Robinul-PH Forte is one blet three times daily (in the morning, early afternoon, and at bedtime). To obtain optimum results, dosage should be adjusted to the individual atient's response. After the more severe symptoms associated with acute conditions have subsided, the dose may be reduced to the minimum equired to maintain symptomatic relief. ■ SUPPLY Robinul Forte (glycopyrrolate, 2 mg.) is available as scored, compressed pink tablets engraved HR/2 in bottles of 100 and 500. ■ Robinul-PH Forte (glycopyrrolate, 2 mg., with phenobarbital, 16.2 mg.) is available as scored, compressed blue blets engraved AHR/2 in bottles of 100 and 500.

A. H. Robins Company, Richmond, Va. A·H·ROBINS



The all-day, all-night summer cold and allergy pill.

Novahistine LP can give your patients the convenience of twice-a-day dosage—morning and bedtime—along with prompt relief from the symptoms of allergic rhinitis, hay fever or summer colds. These continuous-release tablets contain a vasoconstrictor-antihistamine formulation that goes to work rapidly and lasts for hours. Even when nasal congestion is the result of repeated allergic episodes, patients can usually enjoy around-the-clock relief. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

DOW THE DOW CHEMICAL COMPANY, Rx Pharmaceuticals, Indianapolis

Novahistine® LP decongestant

(Each tablet contains 25 mg. of phenylephrine hydrochloride and 4 mg. of chlorpheniramine maleate.)

From the President's Desk



Among my readings I came upon a report of the Philadelphia County Committee to Study the Future of the Private Practice of Medicine. In my opinion this is a masterpiece of its kind.

It is the result of 18 months of deliberation and interviews of both non-medical and medical people concerning the future of the private practice of medicine. It is reprinted with permission from *Philadelphia Medicine* (65:961-963, 1969). I hope you enjoy it as much as I did. The report follows.

M. O. Beamhorn, M.D.

Final Report of the Philadelphia County Committee to Study the Future of the Private Practice of Medicine

And it came to pass in the days of the rule of the great omniscient bifacial King Janus, that, scanning past and future simultaneously, seeing a full 360° at a single whirl of his radar, his senses brought him only the din of discontent, and the sounds of sickness, and the smells of pollution, and the outcries of protest, and the ferment of the witches' cauldron. And he sought in his Computer a likely candidate for the role of Scapegoat. He prayed to the Mighty Machine.

"O, Supreme Being send me that one who is prosperous from the sale of an unpopular product. Deliver unto me that one who is few among us so that his voice may be shouted down. Point out that one whose labors are dedicated to the false gods of selfless devotion in a constant battle where defeat is assured. Select from the multitude that man whose earned fatigue leaves him too weary to defend himself. Make known to me the man whose skills and education are the envy of all. Deliver unto me that one who asks only honest wages for honest work. This one will we crown with goat horns and clothe with goatskin that all may gather and heap their sins upon him to drive him into the desert and thus be sinless themselves."

And the Great Machine whirred and flashed and with not even a puff of smoke delivered to Janus a card bearing the legend "Doctor." And "Doctor" was made to build his own cage out of beams of benefaction and posts of pity and the wire of work. And they put upon him the horns of The Billy and the hide of The Nanny.

And Janus sent The Word to the multitude.

We have found the source of your sorrows. Come heap your sins upon him that ye may now be free of thy burdens and walk upright in the swamp. Ye know that this is the purveyor of health and ye are not healthy. Ye know he lives in a clean house and thine is filthy. I, Janus, now deliver him to thee for thy salvation.

And Carpenter came and cursed him for the poor housing that causes disease; and Electrician lashed him for the darkness that depressed the poor; and Plumber laid on the thorns for the lack of sanitation; and Contractor beat him for the high cost of hospitals; and Administrator scourged him for not wishing to be a hireling; and the Young Tribesmen with shiny stethoscopes and springy steps and upright T-waves, their nostrils not yet filled with the odors of pus and their bones not yet weary with trying, added their sophomoric scorn to his burdens. And the people shouted "We will not pay for Disease" and Doctor wept that they knew not that his product was the minimizing of disease and distress, not their occurrence. And there marched into the courtyard a great group of white coated men, all of whom had already given up all that Doctor had been trying to do: to conquer disease through strength of will, the use of practical knowledge, and devotion to The Worshipful Work. And they spat upon him for his failure to have regular days off. They ridiculed his inability to have tax dodges and retirement benefits. They beat him for giving good medical care at reasonable cost. They said, "We, The Group Practitioners, do it better and cheaper and easier. Our machines will point the way to health and salvation." And they said it so often and so loud and with such conviction that the multitude said that it must be so, for these people wear clean white coats and starched collars and show no signs of having been up all night and bear not the stains and dishevelment of fatigue, and they speak from high places. And Politician heaped upon his head the coals of bad laws and racial prejudice and smeared his face with his own blood that the flies might come to add to his discomfort.

And through the murk of the midwatch Nurse came with water and Patient brought bread.

And when all had had their turn they drove him into the desert pursued by the triumphant howls of his tormentors. And he dwelt in an Oasis of Sorrow and survived on the figs of frustration at being forced to witness the defeat of the Profession and witness the disintegration of the ideals which had been its birthright.

And there was a festival lasting 100 days and 100 nights in which Carpenter and Electrician and Plumber and Contractor and Administrator and the young tribesmen and The Groupers and Politicians and all The People made a joyful noise with tinkling cymbals and sounding brass.

And suddenly Fear arrived at The Festival and, seeking the highest podium and the brightest torch, said, "Hear ye. Ye have said ye need more doctors. Ye have given him his reward. Who now will be a Doctor? Ye Carpenter, ye Politician, ye Financier, will you deliver your sons to The Schools so that they may study and labor to become a Doctor?"

And a thunderous silence fell upon the multitude and each looked agape at his neighbors, half pleading and half questing. And then each drifted away to meditate on this malice.

And they sent representatives into the desert to seek out The Doctor but beneath the sands of The Oasis, beneah the barren Fig Tree they found only a dried skeleton and from the branches of The Tree came the flapping of vultures wings.—**Perry S. MacNeal, M.D., Chairman, Philadelphia. Reprinted with permission from** *Philadelphia Medicine* (65:961-963, 1969). ◄

WANTED: Physicians Locations

ADMINISTRATION

Webb, William M., 1301 Broadway, Millbrae, Calif. 94030.

ANESTHESIOLOGY

Crowe, James Hartley, 11 Sunset Strip, Brewer, Maine 04412

Rodrigo, Bernardo R., 3120 W. School House La., Philadelphia, Pa. 19144

DERMATOLOGY

Gilbert, Alan R., 3007 Somerton St., Cleveland Heights, Ohio 44118

Ryan, Catherine C., 6 Taaffes Lane, St. Johns, Prov. of Nfld, Canada

Farrell, William F., 6641 Monero Drive, Palos Verdes Peninsula, Calif. 90274

Khandekar, Prakash K., 6507 Marsol Road, #447, Mayfield Heights, Ohio 44124

GENERAL PRACTICE

Jeffries, Rex G., Box 1047, Truckee, Calif. 95734

Pena, Adela P., 877 Alandele Ave., Los Angeles, Calif. 90036

GENERAL SURGERY

Alberto, Tiburcio P., 20118 Longbrook, Warrensville Heights, Ohio 44128

Anaya, Emil A., 149 Debra Lane, Buffalo, N.Y. 14207

Bardenheier, Joseph A., 34 Bayside Avenue, Newport, R.I. 02840

Bernard, Roger P., 104 A Polaris, Sheppard Air Force Base, Texas 76311

*Chuntrasakul, Chomchark, Albany Virginia Hospital, Albany, N.Y. 12208

***MacWilliams, Robert, 2816 Hargrave Street, Philadelphia, Pa. 19136

Dillow, Byron M., 3021 Santa Fe Tr., Fort Worth, Texas 76116

Grover, Sarv Mittar, 20 Delsan Court, Buffalo, N.Y. 14216

Kasbekar, Vithal Yeshwant, St. Louis Co. Hosp., St. Louis, Mo. 63105

Krishnamurthi, K. D., 2609 Franklin Blvd., Cleveland, Ohio 44113

Supattanasiri, Gritte, 2609 N. Hampden Ct., Chicago, Ill. 60614

INTERNAL MEDICINE

Ali, Nasir, 981 Joliet Drive, Maumee, Ohio 43537

Bayazit, Lutfi, 2108 North Court, Logansport, Ind. 46947

Gallagher, Hugh S., 24 Hillside Road, Stratford, N.J. 08084

Harinasuta, Udom, Ramathibodi Hospital, Bangkok 4, Thailand

Kobal, Cemil, Adakale Sokak No: 61/9, Yenisehir-Ankara, Turkey

Khan, Abdul H., 687 Pine Avenue, Montreal, Canada

Pfoertner, George B., 15883 East 13th Avenue, Aurora, Colo. 80010

Waltemath, Donald E., 97th General Hospital, APO New York, N.Y. 09757

OBSTETRICS AND GYNECOLOGY

Castro, Antonio E., Rua Goncalves Chaves 454, Pelotas, R.S., Brazil

**Dmowski, W. Paul, 1300 Warren Hites, A-108, Augusta, Ga. 30901

Rodrigo, Tarcila R., 3300 Henry Ave., Philadelphia, Pa. 19129

OPHTHALMOLOGY

**Parikh, Naresh K., 43 Rue Brugere, Ottawa 2, Ontario, Canada

Talley, Terry W., 568 Terrace Lane East, Ypsilanti, Mich. 48197

ORTHOPEDICS

Kaplan, Samuel S., 12730 West 100th Street, Lenexa, Kansas 66215

Nemani, Pandharinath, 901 Vine Street, #103, West Newton, Pa. 15089

Harned, Gerald L., 1537 South Bates, Birmingham, Mich., 48009

PATHOLOGY

Sozer, Muammer, Gulden Sokak No. 6/8, Kavaklidere-Ankara, Turkey

Batata, Mohamad A.M.E., 33 Pond Ave., Brookline, Mass. 02146

Dangle, Harland C., 673 W. Fennville St., Fennvile, Mich. 49408

PEDIATRICS

Elassani, Sami Baqir, University of Mo. Medical Cntr., Columbia, Mo. 65201

Garcia, Antonio, 134 Sabyan, San Antonio, Texas 78218

Hayden, W. R., 1821 E. Grauwyler, #190, Irving, Texas 75060

Vidyasagar, Dharmapuri, 505-21 Clayton Dr., Winnipeg 8, Manitoba, Canada

Channabasappa, Gullehalli, 650 Frith Drive, Nashville, Tenn. 37213

*Vafaie, Akbar, 3300 Henry Avenue, Philadelphia, Pa. 19129

PHARMACEUTICAL

Swan, Robert E., 420 Cherry Street, Evansville, Ind. 47713

PSYCHIATRY

Francisco, Edgardo C., Cottage #4, Nevada State Hospital, Nevada, Mo. 64772

Frisbie, James H., Marshfield Clinic, Marshfield, Wis. 54449

Kohut, John J., 25328 Fay Street, Sunnymead, Calif. 92388

RADIOLOGY

Naga, Ahmed Alhady Abou El, 66 Dexter Terrace, Tonawanda, N.Y. 14150

Restrepo, Roberto, 15680 West Brentwood Drive, Brookfield, Wis. 53005

UNIVERSITY OR U.S. GOVERNMENTAL INSTITUTE

Kelly, Joseph A., 20 Winter Street, Foxboro, Mass. 02035

UROLOGY

Bedi, Bhupinder S., 15 East Kirby, Detroit, Mich. 48202

***Choithani, C.M., 59 Isabella Street, #305, Toronto, Ontario 285

Finn, Richard S., 5440 Cleveland Avenue, #7, Lincoln, Neb. 68504

Wagle, D.G., 30 Brookedge Court, Williamsville, N.Y. 14221

Bhayani, Bipin N., 3220 W. Diversey, #2B, Chicago, Ill. 60647

Kilduff, James T., 8604 25th N.E., Seattle, Wash. 98115

Whang, Ki Jun, 597 Hawkeye Ct., Iowa City, Iowa 52240

*House Physician

**Academic

***Industrial

FUTURE MEETINGS, SEMINARS, COURSES

Two I.U. Physicians to Speak At Detroit Stroke Conference

The "Comprehensive Conference on Stroke" to be conducted by the American Heart Association will be held September 23 and 24 at Cobo Hall in Detroit. Two experts from Indiana University School of Medicine will speak. Dr. Mark Dyken will discuss "Management of the Patient with Acute Stroke." Dr. Robert Campbell will speak on "Spontaneous Subarachnoid Hemorrhage." The conference is open to physicians from Indiana, Illinois, Kentucky, Michigan, Ohio and Wisconsin.

AAOS to Host Emergency Care Course

An advanced practical course on Emergency Care and Transportation of the Sick and Injured, sponsored by the American Academy of Orthopaedic Surgeons, will be held at St. Louis September 27 to 30. Registration is limited to 200. The tuition is $50, which includes luncheons and the AAOS text. For housing, contact the Chase-Park Plaza Hotel, 212 N. Kingshighway, 63110. To enroll, write Dr. Marshall B. Conrad, 4960 Audubon Ave., St. Louis, Mo. 63110.

Symposium on Polytomography Of Temporal Bone Announced

The fourth two-day Symposium on Polytomography of the Temporal Bone will be given under the auspices of The Wright Institute of Otology at Community Hospital, Indianapolis, on October 9 and 10, 1971.

Subjects covered are: "Basic Anatomy of the Temporal Bone" and "Technique of Polytomography of the Temporal Bone" with demonstrations of normal tomograms. Pathological conditions revealed by polytomography, such as cholesteatoma, ossicular chain problems, otosclerosis, fractures, foreign bodies, tumors, and congenital anomalies are shown on original tomograms and the clinical applications discussed.

Number of registrants is limited to 18. Fee for the course is $150.00.

Inquiries should be directed to: The Wright Institute of Otology, Inc., Community Hospital of Indianapolis, Inc., 1500 North Ritter Avenue, Indianapolis, Ind. 46219.

Tumor Conference to Be Held at Houston

"Endocrine and Non-endocrine Hormone Producing Tumors" will be the topic of the 16th Annual Clinical Conference to be held Nov. 11 and 12 at the Shamrock-Hilton Hotel in Houston. Inquiries should be directed to Mrs. Jane Brandenberger, M.D., Anderson Hospital, Texas Medical Center, Houston 77025.

South Florida College Schedules Hospital Problems Conference

The Fifth Annual Conference on "Today's Hospital Problems: An Interdisciplinary Approach" will be held at the Tides Hotel and Bath Club, Reddington Beach, Florida, November 10—13. It is a leadership course for chiefs of staff, hospital administrators and governing personnel or trustees under the sponsorship of the Mound Park Hospital Foundation and the College of Medicine of the University of South Florida. Registration is limited. The fee is $110 (3 lunches included); 20 accredited hours is allowed by the AAGP. Write Postgraduate Medical Education, Mound Park Hospital Foundation, St. Petersburg, Fla. 33701.

Interstate Postgraduate Assembly Set

The Interstate Postgraduate Assembly will be held in New Orleans, November 15 to 18. Advance registration fee is $25, registration at the assembly will cost $35. The program is acceptable for 23½ prescribed and 8½ elective hours by the AAGP. It is acceptable for credit toward the AMA Physician's Recognition Award. For registration blanks and hotel reservation forms write the Interstate at PO Box 5445, Madison, Wis. 53705.

Chicago to Conduct Seventh "Frontiers of Medicine" Series

"Frontiers of Medicine" (seventh series) will be conducted by the University of Chicago on the second Wednesday of each month from October 1971 through May 1972. Each session is from 2 p.m. to 5 p.m. In addition an all-day program will be held on March 31 on "Heart Disease in Children: Practical Aspects of Diagnosis and Treatment." The program is acceptable for 30 elective hours by the AAGP. A fee of $100 covers the entire series, single sessions for $15 for those held in the afternoon and $25 for the all-day program in March. The entire series features recent advances in medicine. For the detailed program and full particulars write Frontiers of Medicine, University of Chicago (BH Box 451), 950 E. 59th St., Chicago 60637.

Preventive Medicine Societies to Meet

Two preventive medicine societies will conduct a joint meeting in Minneapolis on October 10. The American College of Preventive Medicine and the Association of Teachers of Preventive Medicine will sponsor the joint program. Write either organization at 801 Old Lancaster Road, Bryn Mawr, Pa. 19010.

College of Surgeons Schedules 17 Postgraduate Courses

All interested physicians are invited to attend the 57th Annual Clinical Congress of the American College of Surgeons in Atlantic City October 18 to 22. A complete program is planned for general surgery and for each of the surgical specialties. Registration fee for non-members is $90. Surgical residents register free. There will be 17 postgraduate courses, each one accredited by the Council on Medical Education of the AMA. Each course involves a nominal fee. For details write the College at 55 E. Erie St., Chicago 60611.

Western Cardiac Conference Set

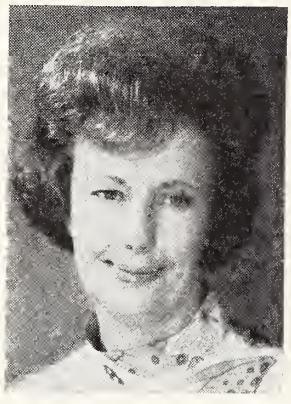
The 18th Western Cardiac Conference will be conducted on October 20, 21 and 22 at the University of Colorado Medical Center. A fee of $35 will apply to participants from outside of Colorado. A distinguished visiting faculty, including **Dr. Harvey Fiegenbaum, Indianapolis,** who will speak on Echocardiography, will participate. ◄

The Woman's Auxiliary

REPORTS TO ISMA

A health message from President Nixon, a roster of prominent speakers, and a record-shattering fund-raising effort for medical education highlighted the 48th annual convention of the Woman's Auxiliary, held June 20-24 in Atlantic City.

Addressing the AMA House of Delegates, President Richard M. Nixon told the AMA that "the responsibility for the health of this nation is in your hands" and called American doctors "the indispensable front-line soldiers" in the effort to end and prevent drug abuse.



"America at this time needs leadership from those in the medical profession, and your wives—the AMA Auxiliary that I know is meeting here in Atlantic City with you—all across this country, not simply in the areas that affect you directly but in the area of national problems," Mr. Nixon said. He warned, "You better get interested in politics or you won't have any profession to be interested in." This we can't let happen.

Giving the keynote address on Monday, Walter H. Johnson, Jr., chairman of the board of Myers-Infoplan International, declared that society has been overspecialized—in education, in the professions, in public affairs—and in so doing we have complicated life and bred frustration.

"Technology forces the continuance of specialization, and women can be the great generalists. They hold the thread of community continuity. They have time in which to change things and they who have given birth to society have a responsibility to see that it is a good one," Mr. Johnson declared.

"Organized medicine has made an enormous contribution to the public health and the national level of health care. Today it is under attack, largely by the political opportunist and the social planner.

"The task is to persuade our citizens that organized medicine has a plan which is a sensible answer to human need without loss of quality in medical service," he said.

Dr. Walter C. Bornemeier, AMA President 1970-71, spoke at the Monday luncheon. Dr. Bornemeier congratulated Auxiliary members for their unselfish devotion and expenditure of time and money to make this country a better place in which to live. In citing auxiliary accomplishments in health careers, environmental health and funds for medical education, Dr. Bornemeier commented that the Auxiliary was "sowing the seeds of inspiration, of leadership and of example."

The Hon. Patricia Reilly Hitt, assistant secretary for community service, Department of Health, Education, and Welfare, addressed the Tuesday luncheon honoring national Auxiliary past presidents and state presidents. She was named to her position by President Nixon in January 1969, after serving as national co-chairman for his 1968 campaign. Mrs. Hitt said there is much that is good about the American health enterprise—and requested that those elements be retained and improved upon. She reiterated the main thrust of any health proposal—preventive medicine with emphasis on keeping people healthy.

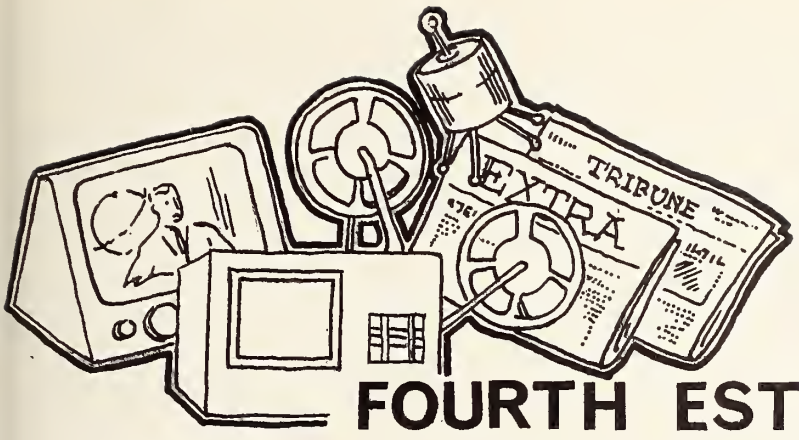
At this luncheon Mrs. R. C. L. Robertson, 1970-71 Auxiliary president, presented the Auxiliary's record-breaking check for the AMA-ERF to Dr. John Chenault, AMA-ERF president. This year's contribution totaled $550,927.01. Of the total, $487,565 was allocated as unrestricted funds for the nation's 113 existing and developing medical schools. Another $62,033 was earmarked for the AMA-ERF loan program.

Mrs. G. Prentiss Lee of Portland, Ore., was installed as president of the Auxiliary on Wednesday, June 23. In her inaugural remarks, Mrs. Lee pointed out that the Auxiliary recognizes the importance of health education and historically has been concerned with health education.

Mrs. Lee encouraged Auxiliary members to maintain their interest and enthusiasm and to use their imagination to help generate faith and pride for medicine. She called on members to add luster to the medical profession by joining forces with the Auxiliary and giving of themselves.

Mrs. Robert F. Beckley of Lock Haven, Pa., was chosen president-elect, and Mrs. Willard Scrivner, East St. Louis, Ill., was named first vice-president.

Lelia M. Chernisky



FOURTH ESTATE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Call the Doctor

The growing dissension and conflict within the *American Medical Association* about the role of physicians in society and what the AMA itself should be doing was never more obvious than at the organization's recent annual meeting.

A revolt of young physicians has been brewing for several years. The interns and residents, who reportedly make up about 20 per cent of the practicing physicians in the country, have been demanding low-cost AMA memberships, and have been pushing for a series of militant resolutions on peace and health matters. The AMA this year voted to allow reduced dues for the group, but provided them only one vote in the AMA's 246-member House of Delegates. The situation could reach a climax if the young doctors split their ties with the AMA and form their own organization, which they threaten to do next fall.

The AMA also has been racked by defections of doctors in states where national membership has been dropped as a requirement for state medical society members. Throughout the country, physician membership has plummeted to roughly 50 per cent, and the resulting loss of dues could cut into the organization's activities.

Other internal issues point to severe strains over the AMA's approach to national health problems and service. Facing the possibility of some form of national health insurance, the delegates revised last year's stand on the individual's right to health care. Instead of simply reaffirming the previous position, as had been recommended by committee, the delegates added language asserting that it's the responsibility of citizens or society to seek care. The physicians also declared that every doctor has the right "to choose whom he will serve and the conditions under which" he will serve them.

It would be easy to read too much into the latter statement, but there appears to be an implication of a physician boycott against any national health insurance program that might be considered an imposition.

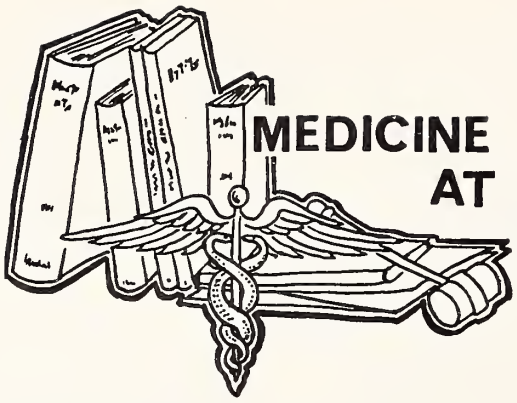
The AMA's convention also provided some fast footwork on drug usage and abuse. Following President Nixon's address to the delegates, the AMA came out with full-page ads in a number of major newspapers saying that the nation's doctors have accepted the challenge to shape the public's attitude on drugs, and "to educate America to the serious dangers of drug abuse." A number of resolutions were proposed that dealt with drug advertising and commercials, and the prescribing of mind-altering drugs. The result was a resolution only calling for limits on the use of amphetamines and other stimulants for "specific, well-recognized medical indications." The question of using amphetamines for weight reduction wasn't covered, although the federal government has come out against the practice, and the *Allen County Medical Society* is starting an experiment that drops them for that purpose.

The AMA's new president also suffered a repudiation from his own board of trustees. Dr. Wesley Hall called for a constitutional convention, the first since 1847, to streamline the organization and "enfranchise" the young physicians. The trustees said a convention isn't necessary, and the delegates postponed action on it.

A certain amount of factionalism and bitterness can be expected in any organization as large and diverse as the AMA. The defections of dues-paying doctors and the threat of a splinter organization, however, suggest some basic disagreement or disinterest in the AMA's policies and programs. It's revised stand on health care could be highly important if it leads to another confrontation similar to the disastrous battle over Medicare.

It's not at all assured that the AMA's official vision of medical leadership and responsibility in the delivery of quality health service, and in other issues, coincides with what a growing number of physicians, the public and Congress may expect. That's the point when the AMA's internal problems become everone's concern.

How the AMA handles drug abuse, national health insurance and the revolt of the young physicians will indicate much about the organization's ability, and willingness, to adapt to changes and new demands. The ability to self-prescribe is vital. —*Fort Wayne Journal Gazette*, July 1, 1971.



MEDICINE AT LAW

Hospital Liable for Injuries from Elbow Immobilizer— A woman who suffered an injury to an ulnar nerve after the use of an elbow immobilizer in a recovery room was awarded $7,500 damages against the hospital by a California jury. However, no damages were assessed against the physicians.

A 74-year-old housewife was hospitalized for removal of her gallbladder. In the recovery room after the operation, an elbow immobilizer was used to keep her left arm straight and keep in place a needle used to administer intravenous fluids. The immobilizer was held in place by a strap applied directly over the ulnar nerve.

The patient brought action for negligence against the hospital and three of the hospital's physicians. She contended that she suffered compression of and injury to the ulnar nerve at the level of the olecranon process as a result of the immobilizer strap being applied too tightly.

The physician who testified for her said she had sustained a compression type injury to the ulnar nerve. He further testified that he thought she had recovered completely, even though she was still complaining of pain and limitation of motion in her hand. Electromyelograms taken after she left the hospital showed complete electrical regeneration of the ulnar nerve at the level of the elbow.

The hospital and the treating physicians contended that the patient did not receive an injury while in the hospital. They pointed out that her admitting history showed paresthesia in the ulnar distribution. They further contended that neurologists who treated the woman at another hospital decided that her problems were caused by a lesion in the cervical spine. Two of the physicians testified that the nurses did not deviate from the appropriate standard of practice in the application of the elbow immobilizer.—*Giles v. Community Hospital of Monterey Peninsula* (Cal.Super.Ct., Monterey Co., Docket No. 67474, 1970).

Drug Overdose Held Accidental Death—The finding of a jury that a woman's death from a drug overdose was an accidental death was not set aside by a New York trial court. The woman's mother was held entitled to receive double indemnity benefits under the terms of the woman's life insurance policy.

The woman, 23 years old, had been addicted to heroin for several years. She died of "acute and chronic intravenous narcotism." The company with which the woman had maintained a $1,000 life insurance policy conceded that she had not committed suicide. However, the company refused to pay double indemnity benefits, contending that death from a self-inflicted injury is not an accidental death.

The woman's mother, the beneficiary under the insurance policy, sued the insurance company. She introduced expert medical testimony that heroin addiction is not a mental or a physical disease, that an injection of heroin is not an injury, and that an addict does not take a narcotic in order to kill or harm himself.

The insurance company produced medical experts who testified that addiction is a serious psychiatric disease. They also testified that every addict is aware of the possibility of death from an overdose. Their opinion was that the woman's death was not an accident.

Returning a verdict in favor of the woman's mother, the jury specifically found that the woman's death was accidental. The trial court refused to set aside the jury's verdict.

The medical evidence was neither incontrovertible nor conclusive, the court noted. Each side introduced medical evidence to support its position. In such a case, the court ruled, it was the jury's function to decide an issue of fact.—*Davis v. John Hancock Mutual Life Insurance Company*, 316 N.Y.S.2d 722 (N.Y., Civil Ct. of the City of N.Y., Dec. 24, 1970).

Malicious Prosecution Claim Disallowed in Malpractice Suit— A counterclaim for malicious prosecution may not be maintained in a lawsuit for medical malpractice, the Supreme Court of California ruled.

A woman retained an attorney to represent her in a malpractice claim against a physician. After the case was filed, the physician filed a counterclaim in the same lawsuit. The counterclaim was for malicious prosecution, and was against both the woman and her attorney. The motion of the woman and her attorney to dismiss the counterclaim was denied. They appealed.

Reversing the order, the state supreme court ruled that before an action for malicious prosecution may be brought, the original judicial pro-

ceedings must first end in the physician's favor. To rule otherwise, the court said, would put the suing party and her attorney in potentially adverse positions.—*Babb v. Superior Court of Sonoma County*, 92 Cal. Rptr. 179, 479 P.2d 379 (Cal. Sup. Ct., Jan. 15, 1971).

Patient Jailed in Collection Suit Sued Physicians—A patient's action for damages against physicians, complaining of false imprisonment, mental anguish and humiliation when he was jailed for failure to appear in court in connection with an attorney's suit to collect the physicians' bill, was properly dismissed, an Illinois appellate court held, because the patient's complaint was insufficient in its allegation of facts.

When a patient did not pay a bill for $230, two physicians placed it with an attorney for collection. A suit was filed against the patient, and a summons was served on him. Three days later he paid $100 directly to the physicians. Because neither he nor the physicians notified the attorney or the court of the partial payment, the court entered a judgment for $230 plus costs in the amount of $6.50 against the patient.

Although the attorney subsequently learned of the payment, he obtained issuance of a citation because of the balance due. The patient continued to make partial payments directly to the physicians, but did not take into account the accruing court costs and did not notify the attorney of the payments. Two additional citations were served on the patient, which he ignored as he had the previous ones.

Finally, the patient made a payment of $25 with a check on which there was a notation "paid in full" and received a receipt showing his account was paid in full. He allegedly requested that the attorney be notified that the account was paid, but this apparently was not done.

When the patient failed to appear in court at the time indicated on the last citation, the court ordered him to appear to show cause for contempt. When he again failed to appear, the court directed the sheriff to bring him to court to answer the contempt charge. He was incarcerated in the county jail and informed that he would be released upon payment of $35.20 as a balance on the doctors' bill and $54.16 for costs. His wife paid the bills, and he was released.

The patient brought action for damages against the physicians, complaining of false imprisonment, mental anguish, and humiliation and that he was deprived of his liberty and property in violation of his constitutional rights. The trial court dismissed the complaint for failure to state a cause of action, and the patient appealed.

The appellate court said that the patient had been served with all of the required notices and that he was therefore not deprived of his liberty without due process. The court described the complaint as a document fraught with confusion, conclusions, ambiguities, misstatements, contradictory statements, inconsistencies and inaccuracies and held that it was insufficient to sustain a valid cause of action.—*Richards v. Leimbacher*, 267 N.E.2d 523 (Ill.App.Ct., March 3, 1971). ◄

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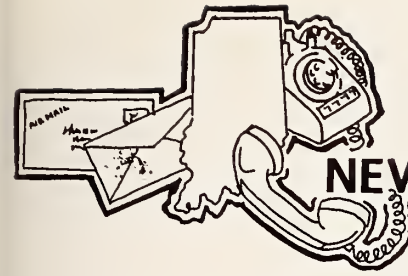
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NEWS NOTES

Physicians Elected, Re-Elected by AAGP

A number of Hoosier physicians have been elected to membership in the American Academy of General Practice. Among those so honored are: **Drs. Herbert K. Acker, Fort Wayne; William F. Blaisdell, Seymour; John P. Calhoon, Plainfield; Alfred C. Cox, South Bend; Donald R. LaFollette, New Albany; Dean Lloyd Mattox, Howe; Thomas J. Stoltz, Otterbein; and J. B. Wohlfeld, Bedford.**

Among those re-elected to active membership in the Academy are **Drs. N. C. Johns, South Bend; Donald J. Parrot, Fort Wayne; John Joseph Reed, Hobart; William D. Scharbrough, Brownstown; and Paul Allan Williams, Rensselaer.**

Take Part in Dedication Ceremonies

Drs. Daniel Evans and Leonard Green, Valparaiso, took part in a seminar held in connection with the dedication of the Valparaiso University's College of Nursing building.

Burned Patient Topic of Lecture

Dr. Andrew Y. S. Chau, Terre Haute, lectured on management of the severely burned patient in one of a series of learning sessions offered nurses by the patient care department of Union Hospital recently.

Dr. Lyster Cited as Diplomate

Dr. Richard F. Lyster, Fort Wayne, has fulfilled requirements of the American Board of Orthopedic Surgery and is now a diplomate of the board.

Robins Advertising to Stress Importance of Preventive Medicine

The A. H. Robins Company of Richmond, Va., has started a new series of institutional advertising which will stress the importance of people seeing their physicians before they are sick. The first ad of the series is captioned "The best time to see your doctor is when you're feeling great." The series will run in TIME, as did the preceding sequence which dealt with medical education and training. A. H. Robins solicits the reactions and comments of physicians and invites written discussion of the preventive medicine presentations.

Celebrates 50 Years with Clinic

Dr. Carroll C. Hyde, South Bend, 78, was recently honored at a dinner given by physicians of the South Bend Clinic and their wives for his 50 years with the clinic.

A member of the American College of Surgeons, the American Board of Urology, the American Urological Association, he is a past president of the St. Joseph County Medical Society.

Three Serve on Abortion Panel

Three Fort Wayne physicians participated in a panel discussion on abortion at the Indiana-Purdue environmental teach-in recently: **Drs. Arthur F. Hoffman, Richard Juergens and George C. Manning.**

Speaks at Conference for Women

Dr. Ramona Middleton, Elkhart, was one of the speakers at the 15th Conference for Women held at Oaklawn Center recently. Her topic was "Body and Soul—That Marvelous Mystery —Woman."

Hospital Supply Appoints Anderson

Michael H. Anderson, who has been serving as corporate public relations administrator for Miles Laboratories, has been appointed assistant director of advertising and public relations for American Hospital Supply Corporation.

Dr. Keyes Speaks at Winamac

Dr. Robert Keyes, Fort Wayne pediatrician, was one of the speakers at a recent "Women's Worry Clinic" held at Winamac under the sponsorship of the Mental Health Association of Pulaski County.

Dunkirk Honors Dr. Shroyer

Introduced as "the grand old man of Dunkirk," **Dr. Herbert L. Shroyer** presented the first annual Dr. H. L. Shroyer Christian Scholarship to a graduating senior at the Dunkirk High School commencement exercises recently.

Posthumous Honor Among Two Awards Made to Fort Wayne Physicians

Dr. Charles S. Giffin and the late **Dr. Emil Bergendahl,** both of Fort Wayne, were elected fellows of the American Laryngological, Rhinological and Otological Society, Inc. at the society's recent meeting in San Francisco. The award to Dr. Bergendahl was made posthumously.

New Booklet Published Which Reviews Controversy over Brands and Generics

The Pharmaceutical Manufacturers Association has published a 118-page book which reviews the controversy over brands and generics in prescribing. The title is "The Prescribing Debate." Some of the conclusions are that (1) the terms brand name and generic should not be used as indices of quality; (2) consistently reliable drug products, whether sold by trademarks or without, are not as commonplace as assumed by the government, by the layman, or even the professionals; and (3) the overall savings to be expected from a complete overthrow of the trademark concept are small, while the cost that would be involved in attempting to equalize all drug makers and alter established prescribing practices would be unacceptably high. Single copies will be made available without charge by writing PMA at 115 Fifteenth St., N.W., Washington, D.C. 20005. Quantities may be ordered at $1.00 per copy.

Named President-Elect

Dr. Robert M. Raber, Indianapolis, was chosen president-elect of the Ohio Valley Society of Plastic and Reconstructive Surgery at the group's recent meeting in Dayton. Dr. Raber had been serving as secretary-treasurer for the past year.

1971-72 Officers Named by History of Medicine Society

At the annual business meeting of the John Shaw Billings History of Medicine Society held recently new officers were elected for the coming year. They are: President, Dr. Charles A. Bonsett; vice president, Dr. William DeMyer; secretary-treasurer, Dr. Roy J. Korn; and, program chairman, Dr. Hanus Grosz. The outgoing president is Dr. William M. Loehr. All are of Indianapolis.

Laser Film Offered by Upjohn

Upjohn has a new medical 19-minute film on the "Clinical Applications of Lasers." It is in full color with sound, 16 mm wide. It deals with the use of lasers in neurosurgery, ophthalmology and dermatology and is on a free-loan basis. Requests for prints, listing alternate dates, should go to Upjohn Professional Film Library, 7000 Portage Road, Kalamazoo, Mich. 49001.

Dr. Eugene Klatte Chosen to Head I.U. Radiology Department

Dr. Eugene C. Klatte, a graduate of Indiana University School of Medicine, at one time a Picker Scholar in radiological research and instructor in radiology at I.U., and most recently chairman of the Department of Radiology at Vanderbilt University, will become chairman of the Department of Radiology at Indiana. He succeeds Dr. John A. Campbell, who will head the Department of Radiology at the Drew Postgraduate Medical School in Los Angeles.

Evansville Orthopedist Returns from Vietnam

An Evansville orthopedic surgeon who has spent his vacations for seven years on the SS Hope changed his program this year and went to Vietnam. **Dr. Francis Zeier** participated in the Volunteer Physicians for Vietnam program sponsored by U.S. Aid for International Development (AID).

Medical Society Dance Raises Funds for Hospital

Dr. Antolin M. Montecillo, who served as chairman of the Parke-Vermillion Medical Society benefit dance committee, presented a check for $1700 to the board of trustees of the Vermillion County Hospital. The sum represented the proceeds of a dance held in June and will be the start of a fund to incorporate a recovery room into the hospital facilities.

Dr. Kress Named to Health Department

Dr. James W. Kress, Muncie, who has been serving as a member of the Muncie board of health, has been named as one of the city's representatives to the board of the newly created City-County Health Department. The new board will serve all of Delaware county beginning next year.

Drs. Barbara Backer, Edwin C. Mueller Honored at LaPorte Ceremonies

When **Dr. Edwin C. Mueller, LaPorte,** was presented the Outstanding Citizen Award at ceremonies hosted by the LaPorte Jaycees recently, the presentation was made by last year's winner, **Dr. Barbara Backer,** the first woman to be accorded that honor.

A few weeks later Dr. Backer was on the receiving end when awards were being handed out. She was named "LaPorte Area Woman of Achievement" for 1970 and received a gold medallion, cast for the occasion.

Geriatric Amputee Booklet Offered

Guidelines for physicians and allied health personnel on the treatment and rehabilitation of geriatric amputees are contained in a new monograph available from the National Research Council. "The Geriatric Amputee: Principles of Management" is available at $3.50 per copy by addressing the Printing and Publishing Office, National Research Council, 2101 Constitution Ave., N.W., Washington, D.C. 20418.

Governor Names Two Physicians To Drug Abuse Advisory Committee

Recent appointees by Governor Whitcomb to the Department of Mental Health's advisory committee on drug abuse are **Drs. Ivan Bennett and Dwight Schuster,** both of Indianapolis. **State Health Commissioner Dr. Andrew C. Offutt** also serves on the committee.

Dr. Grabow Speaks at Colton

Dr. E. F. Grabow, Hammond, discussed children's eye problems at a recent meeting of the Dolton Challenge Organization.

Backers Return from Guatemala

Dr. and Mrs. H. G. Backer, Ferdinand, spent a month this spring on a medical aid trip to Central America which was under the auspices of the Holidays for Humanity program. Dr. Backer, who is 72, was assigned to the Coban area of Guatemala. When asked if he intends to go back, the physician answered, "Oh, yes, of course."

Electricity Safety Booklet Offered

"Manual for the Safe Use of Electricity in Hospitals," published by the National Fire Protection Association, can be obtained for $2.50 the copy, by writing the Association at 60 Batterymarch St., Boston 02110.

Ostomates Hear Dr. Grillo

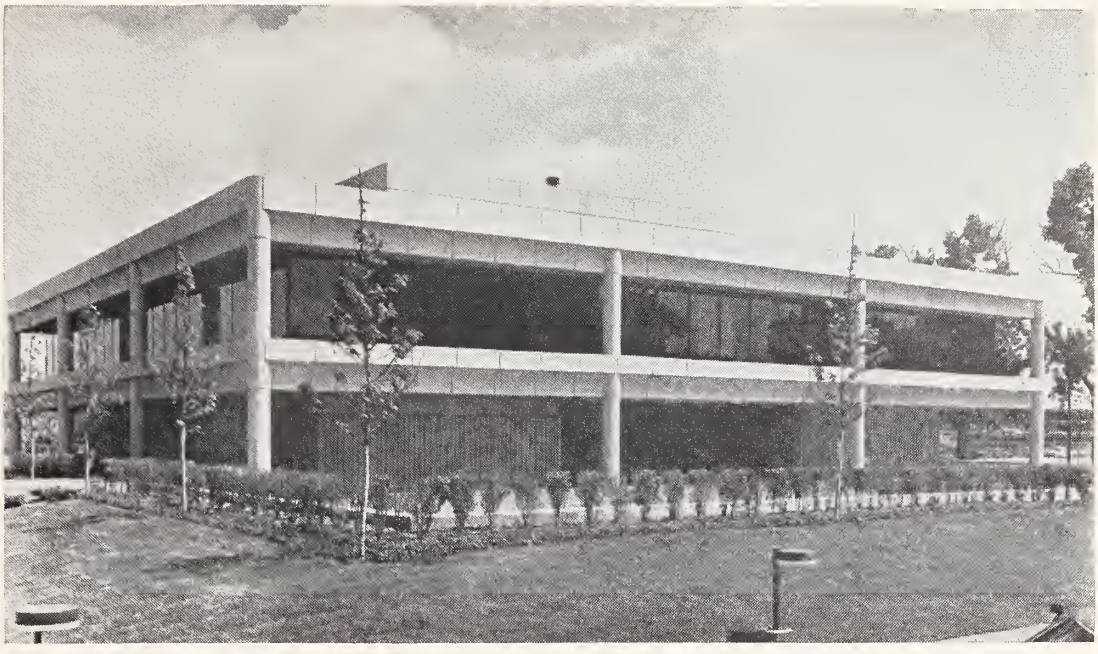
Fifty interested and concerned ostomates and their spouses attended a recent meeting of the St. Joseph County Ostomy group at which **Dr. Donald Grillo, South Bend,** was the featured speaker. Members of the LaPorte County Ostomy group were guests.

Speaks at Drug Abuse Program

One of the speakers at a recent Hancock County program on drug abuse and illegal drug traffic was **Dr. John E. Moenning, Greenfield.**

Lafayette Hosts Emergency Trauma Care Symposium

The second annual emergency trauma care symposium was given recently in Lafayette by the I.U. School of Medicine in conjunction with St. Elizabeth Hospital and Lafayette Home Hospital. The course, acceptable for six prescribed hours credit by the American Academy of General Practice, presented trauma from various medical viewpoints. Participants were **Drs. Lindley H. Wagner, James E. Hull, Charles Rutherford, James Keplinger, Brice Fitzgerald, Marc Ralston, all of Lafayette, and James Bennett of Indianapolis.**



THE new $2,500,000 Educational Center of the American Society of Clinical Pathologists was dedicated recently in the West Side Medical Center of Chicago. The building is the only one ever constructed by a medical society specifically for the continuing education of its membership. Weekly seminars and workshops will be held in the modern structure to train pathologists and medical technologists in the very newest techniques and methods of clinical pathology.

Accidental Poisoning Booklet Offered

A new Public Affairs Pamphlet outlines how to protect children and adults from accidental poisonings in the home. The 28-page booklet by Arthur S. Freese covers all the common hazards and gives rules for protection against them, especially in the case of toddlers and preschoolers. Available by writing Public Affairs Committee, 381 Park Avenue South, New York City 10016. Price is 25 cents.

Orthopedic Research Laboratories Named for Dr. William T. Green

Dr. William T. Green, who received the M.D. degree from Indiana University in 1925, has been highly honored by the recent dedication in Boston of the "William T. Green Laboratories for Orthopedic Research." The Laboratory is associated with the Children's Hospital Medical Center which is a part of Harvard Teaching Center. Dr. Green was honored by Indiana University by the conferring of the honorary degree of Doctor of Science in 1960. He was the recipient of the I.U. Distinguished Alumnus Award in 1968. He had been clinical professor of orthopedic surgery and co-chairman of the department from 1947 until his retirement in 1970. His research work included rheumatoid arthritis, osteomyelitis, cerebal palsy and poliomyelitis. Since retirement from his teaching post he has been in private practice in Boston.

Dr. Strecker Speaks to Vigo County Group

"Chronic Respiratory Disease" was the subject of the talk given by **Dr. William Strecker, Terre Haute,** at the annual meeting of the Vigo County Tuberculosis Society.

Dr. Deitch Becomes Charter Fellow

Dr. Robert D. Deitch, Indianapolis, has been made a Charter Fellow of the American Society of Ophthalmic Plastic and Reconstructive Surgery.

Dr. James C. Miller Heads Health Board

Dr. James C. Miller, Greensburg, was recently named to the Decatur County Board of Health and will serve as president of the board.

Dr. Jack Collins Chairs Panel

At a recent meeting of the Northeast Indiana Heart Association **Dr. Jack T. Collins, Bluffton,** served as chairman of a panel discussion on "Blood Fats and Your Health." **Dr. Harry D. Tunnell, Fort Wayne,** is president of the association.

Adolescent Health Care Pamphlet Offered by Public Affairs Committee

"Health Care for the Adolescent" is the subject of Public Affairs Pamphlet No. 463, just published. It is authored by June V. Schwartz, M.D., for the guidance of families with adolescent components. Development from childhood to adulthood involves many emotional and behavioristic problems and, at the same time, is usually a period when personal medical help is not available. "Too old for the pediatrician and too young to have a regular adult style doctor." The pamphlet is available for 25 cents by writing Public Affairs Committee, 381 Park Avenue South, New York City 10016.

Cited for 33 Years of Service

Dr. J. W. Strayer, Lafayette, who has served the Tippecanoe County Tuberculosis Association as a board member and medical director for the past 33 years, was honored at the association's recent annual meeting.

Radiologist Speaks to Hospital Auxiliary

Dr. William V. Johnson, New Albany radiologist, discussed the Floyd County Memorial Hospital's x-ray department at a recent meeting of the hospital's auxiliary. He is president of the medical staff.

AMA Offers Peer Review Manual

A *Peer Review Manual* has been published under the auspices of the AMA Council on Medical Service. Copies are obtainable at $4.00 each by writing Division of Medical Practice, 535 N. Dearborn, Chicago 60610.

Dr. Winter to Serve on Scouting Board

Dr. William P. Winter, Martinsville, was elected to the board of directors of the White River Council of Boy Scouts at the group's recent annual appreciation dinner.

GE Rechargeable Cardiac Pacemaker Cited as Significant New Product

The General Electric rechargeable, cardiac pacemaker has been cited as one of the 100 most significant new technical products for 1970. The pacemaker is not only small and light in weight (one cubic inch in volume and two ounces by weight) but may be recharged by having the patient wear a special vest for an hour each week. An alternating current field in the vest recharges the battery without creating any sensory effect for the patient. The pacemaker monitors its own voltage. The device has a potential lifetime of 20 years.

Marion Hospital Chooses Staff Officers

Dr. Max Ganz will serve as chief of staff at the Marion General Hospital during the coming year and **Dr. Max R. Long** will be assistant chief of staff. **Dr. James D. Reid** will serve as secretary.

Attends Aviation Seminar

Dr. Floyd B. Coleman, Waterloo, aviation medical examiner for the department of transportation, Federal Aviation Administration, attended an aviation medical seminar in Chicago recently. The seminar is a part of the continuing medical education program required of aviation medical examiners.

Dr. Webb Co-Authors Pharmacy Textbook

Dr. O. Lynn Webb, physician at the Henry County Clinic in New Castle, is co-editor along with Dr. C. W. Blissitt, Dean of the University of Oklahoma School of Pharmacy, of a text for senior pharmacy students to be used in courses in clinical pharmacy. The text is entitled *Clinical Pharmacy Practice* and is published by Lea and Febiger, Philadelphia.

Terre Haute Resident Wins Pfizer Scholarship

Pfizer announces the award of a college scholarship to Douglas L. Hayworth of Terre Haute. Hayworth is one of 14 recipients nationwide who will receive either a Pfizer or John E. McKeen scholarship this year. The awards are made annually to children of Pfizer employees who intend to study science, engineering, business or liberal arts. Hayworth, the son of Wilford L. Hayworth, who works in maintenance at the Terre Haute plant, will major in philosophy at Indiana State University.

Three Instruct at TB Workshop

Drs. F. B. Warrick, Glen A. Ramsdell and R. A. Weitemier, Richmond, served as instructors at a workshop on tuberculosis held June 29 under the cosponsorship of the Wayne County health department and the county TB and Respiratory Disease Association. All three physicians recently completed a course in "TB Today" at the National Communicable Disease Center, Atlanta, Ga.

Receives National Scout Award

Dr. Richard Gripe, Lafayette, was awarded the Distinguished Eagle Scout Award at a recent Scouter Appreciation program in Lafayette.

Venereal Disease Clinic Held

A statewide symposium on venereal diseases was held recentl on the Indiana State University campus. Among the participant were **Drs. Paul E. Humphrey and Hubert T. Goodman** both of Terre Haute. Dr. Goodman is county health commissione and Dr. Humphrey is president of the Vigo County Medica Society.

Pharmaceutical Manufacturers Announce Clinical Pharmacology, Other Awards

The Pharmaceutical Manufacturers Association Foundation an nounces $203,200 in research and education projects for insti tutions of higher learning. These include three research programs one workshop, and two-year fellowship awards to six scholars fo training in pharmacology-morphology. Also fourteen medical stu dents were given $1000 stipends as trainees in clinical pharma cology. The Foundation has provided approximately $3 millio for research and education since 1965.

Drs. Arata, Bennett, to Head Surgeons

Dr. James E. Bennett, Indianapolis, director of plastic surger at the Indiana University School of Medicine, has been chose president-elect of the Indiana Chapter of the American College o Surgeons. He succeeds Dr. Justin E. Arata, Fort Wayne, who ha been installed as chapter president.

Dr. Arthur Records Cited For 50 Years of Service

Dr. Arthur Records, a 1921 graduate of the Ohio State Uni versity Medical School, received a 50-year pin from the unive sity recently. Dr. Records has been a general practitioner i Franklin for nearly 50 years, and recognition of his long servic to the community was one of the highlights of the annual meetin of the Johnson County Medical Society.

Dr. Carter Moves to Syntex Corporation

Dr. Kenneth Carter, formerly vice president of research and mec ical affairs at Ames Company and for Miles Laboratories, has bee appointed vice president of regulatory affairs for Syntex Corpo ation.

Dr. Lawler Appointed Chairman

Dr. John F. Lawler, Evansville, has been appointed chai man of the north central area in the alumni division of th Baylor College of Medicine's $30 Million Endowment Campaig

Dr. Davis Gets Masonic Honor

The Masonic 50-year award for membership was presented o June 26 to **Dr. Carl Davis,** for 45 years a Valparaiso physician

Coronary Care Dr. Hibner's Subject

Dr. Nolan Hibner, Monticello, addressed the White Count Exchange Club at a recent meeting. His topic was coronary car and the advances that have been made in combating heart disease

Physicians Honored at Methodist Hospital

Staff physicians at Methodist Hospital, Indianapolis, presente a recognition plaque to **Dr. William N. Wishard, Jr.,** for hi 43 years' service in the hospital's graduate medical educatio program. Among others honored at the same time were **Dr Morton E. Tavel and William D. Gambill,** who were recipient of distinguished teacher plaques.

Dr. Combs Speaks To TB Association

Dr. Daniel Combs, Vincennes, was the featured speaker at the annual meeting of the Knox County Tuberculosis Association recently.

Drs. Gullett, Weisenberger Chosen By American College of Preventive Medicine

The American College of Preventive Medicine announces that **Dr. A. Dale Gullett of Columbus** has become a Fellow of the College. **Dr. Brockton L. Weisenberger of Columbus** was made an Associate Fellow.

Support for Investigators Offered by Heart Association

Dr. Thomas Brown, president of the Indiana Heart Association, has announced that investigators may now apply to the American Heart Association for support of studies to be conducted in the fiscal year beginning July 1, 1972. September 15, 1971, is the deadline. For full details write the Indiana Heart Association at 615 N. Alabama, Indianapolis 46204.

ACP Elects Dr. Kenneth Kohlstaedt

Dr. Kenneth Kohlstaedt, Indianapolis, was recently elected vice president of the American College of Physicians at the annual meeting in Denver.

Radiologic Diagnosis Sets Offered

The American College of Radiology has devised and will distribute a set of home-study tests and syllabus sets for use by its members and by other physicians as a self-evaluation test. The cost to enroll is $45 to College members, $35 to residents and $65 to other non-members. The test will be available as separate units in radiologic diagnosis of chest, bone, gastrointestinal, genitourinary, and head & neck. Write to the College at 20 N. Wacker Drive, Chicago 60606.

To Direct Oklahoma City VA Hospital

Dan J. Macer, at one time administrative assistant at the Deaconess Hospital, Evansville, later assistant director of the VA hospital at Fort Wayne and most recently director of the Pittsburgh VA hospital, will be the director of the Oklahoma City VA hospital.

Alabama University Appoints Snively

Dr. William Snively, Jr., Evansville, has been named a division visiting professor by the University of Alabama in Birmingham School of Medicine, Division of Continuing Medical Education.

Dr. Leland Phipps Honored For 50 Years of Service

Dr. Leland K. Phipps, Union City, who retired at the end of 1970 after 50 years of practice, was honored at a dinner party on June 26. The mistress of ceremonies at the dinner was another Union City physician, **Dr. Susan Pyle.**

Honored for Long Hospital Service

Doctors who have served on the staff of the Elkhart General Hospital for 25 years or more were honored at a dinner meeting recently. Among those so honored were **Drs. George Bloom, J. W. Hannah and E. P. Mininger, Elkhart, and Dr. J. R. Lionberger, South Bend.**

Named to Head Buffalo VA Hospital

John R. Rowan, at one time chief of personnel and later assistant hospital director at Indianapolis, has been appointed director of the Buffalo, N.Y., VA hospital.

Dr. Gregg Sheehan Workshop Speaker

A day-long workshop on "Understanding Special Needs of Teenage Expectant Parents" was held recently by the Family and Children's Service of Evansville. One of the speakers was **Dr. Gregg Sheehan** of the Welborn Clinic.

Conference on Blindness In New York in November

The National Society for the Prevention of Blindness will conduct its Annual Conference at the Roosevelt Hotel, New York Ciy, on November 17, 18 and 19. Papers, panel discussions and seminars on the latest developments in detecting and combating blinding eye disease, eye health programs and programs for industrial and school eye safety will be on the program.

Dr. Burney Announces National Committee To Study Nursing, Nursing Education

Dr. Leroy Burney, president of the National Commission for the Study of Nursing and Nursing Education, announces the formation of a national advisory committee to provide guidance to the Commission. The committee "will assist in determining and evaluating specific activities designed to facilitate state, regional and inter-professional acceptance of recommendations which have emerged from the previous three-year study of the nursing profession."



Sometimes, Doctor, I can't help wondering . . . are we really helping?

"Dr. B. J. Matthews Day" Held At St. Francis Hospital

Friends, patients and associates of **Dr. B. J. Matthews, Indianapolis,** were invited to attend a reception and program in his honor on Sunday, May 16, by the Sisters of St. Francis and administration of St. Francis Hospital, Beech Grove.

A native of Loogootee, Dr. Matthews went to St. Francis as anesthestist in 1932 and opened offices for private practice on East Tenth Street, Indianapolis, that same year, where he practiced until his retirement in 1970. He is still active at the hospital as anesthestist.

Speaks to Parents Organization

Dr. Herbert Arbeiter, Munster pediatrician, spoke at a recent meeting of the Parents Organization of Munster. His topic was "Poisoning and Our Children."

Lederle Receives Humanity Award

Lederle Laboratories was the recipient of the San Francisco State College Alumni Association's "Humanity Award" for leadership and concern with environmental problems. Dr. S. I. Hayakawa, president of the college, presented the award. Lederle has sponsored medical symposiums to help alert physicians to the causes and problems of pollution-related illnesses.

Dr. Hamburger Speaks to Dietitians

Dr. Richard J. Hamburger, Indianapolis, assistant professor at the Indiana University School of Medicine, spoke on "Diabetes and Chronic Renal Failure—Conservative Management" at a recent meeting at Bloomington sponsored by the diet therapy section of the Indiana Dietetic Association.

Smokers Target of Five-Day YMCA Program

Dr. H. G. Hebard, Jr., Lafayette, was one of those who conducted a five-day program recently at the Greater Lafayette YMCA on how to stop smoking. The program was sponsored by the National Health Foundation and Research Institute.

Dr. Buehl to Head Health Center

Dr. Frederick H. Buehl, Vincennes, was a recent speaker at a meeting of the Knox County Mental Health Association. He spoke about the new comprehensive community health center established at Good Samaritan Hospital which he will direct.

Cancer Society Elects Dr. Megenhardt

Dr. Dennis S. Megenhardt, Indianapolis, has been elected a director of the Little Red Door, Marion County Career Society and the Indiana Cancer Society. He spoke at the career group's annual meeting on "Living with Cancer."

Six Honored for 227 Years of Service

Six physicians on the staff of St. Joseph Hospital, Logansport, were honored recently for their years of service to the hospital. Citations were presented for a total of 227 years of service, as follows: **Drs. Paul H. Wilson, 49; E. L. Hedde, 41; Charles Wise, 37; Kenneth Kraning, 36; W. K. Newcomb, 34; and Earl Bailey, 30.**

Dr. Bowen Named "Alumnus of the Year" By Medical School Alumni Association

Dr. Otis R. Bowen, Bremen, was named Alumnus of the Year and **Dr. Donald G. Kleopfer, Fort Wayne,** was installed as president of the Alumni Association of the School of Medicine of Indiana-Purdue University, Indianapolis, at its 24th annual meeting recently.

Named president-elect was **Dr. Harold M. Manifold, Bloomington.** Officers re-elected were **Dr. George F. Rapp,** vice president; **Dr. Olga Bonke Booher,** secretary; **Dr. Lester D. Bibler,** treasurer; and **Dr. J. L. Arbogast,** historian. All the latter are of Indianapolis.

Participates in Church Program on "Christian Understanding of Sex"

Dr. Thomas Keough, Warsaw, was a speaker at the First United Methodist Church of Warsaw on "Physiology of Sex." The evening program was one of four scheduled by the church.

Dr. James McBride Honored

Sixty-seven persons were present at a dinner meeting recently to pay tribute to **Dr. James S. McBride,** who after 30 years, was retiring as the Rush County Tuberculosis and Respiratory Disease chest clinician. Because of ill health, however, Dr. McBride was unable to be present.

On Abortion, Sterilization Panel

Drs. Barbara Backer and Robert M. Kelsey, LaPorte, were members of a panel which discussed abortion and sterilization before the St. John's Lutheran Church parent-teacher organization recently.

Dr. William R. Kirtley Receives Banting Medal

Dr. William R. Kirtley, Indianapolis, received the Banting Medal at the 31st annual meeting of the American Diabetes Association in San Francisco in June.

Dr. Kirtley is director of medical research for Eli Lilly & Co.

This year marks the 50th anniversary of the discovery of insulin by Canadian scientists Charles H. Best and Frederick G. Banting.

Dr. John Hartman to Head TB Ass'n

Dr. John Hartman, Angola, was elected president of the Steuben County Tuberculosis Association recently.

Vanderburgh County Physicians Honored

From the Newsletter of the Vanderburgh County Medical Society we learn that Dr. John D. Wilson has been appointed chairman of the 1972 State Officers' Conference Committee for the American Academy of General Practice; Dr. Joseph McCarthy has been elected a Fellow of the Royal Society of Health, London, England; Dr. Ronald W. Sowa has been named a Fellow of the American College of Surgeons and is also certified as an orthopedic surgeon; and Dr. Thomas F. Teller is a newly designated Fellow of the American College of Pathology.

Dr. Dwight H. Murray Cited

Dr. Dwight H. Murray, Napa, Calif., was recently made an affiliated member of the Institute of Brothers of the Christian Schools. He was only the second non-Catholic in three centuries to be so honored by the Catholic teaching order. An honorary member of the Indiana State Medical Association, Dr. Murray is a former AMA president and honorary president of the California Medical Association. He was cited for more than 35 years of charitable medical services.

Dr. Clarence Boone to Serve On State Education Committee

Dr. Clarence Boone, Gary, has been named to a 21-member committee to determine the best method for selecting the state school superintendent and to prepare a reorganization plan for the superintendent's office. The appointments were made by State School Superintendent John J. Loughlin.

Dr. William Nowlin Participates In Panel Discussion at Gary

The division of nursing, Indiana University Northwest, recently sponsored a one-day conference on "The Dying Person and His Family." One of the features of the conference was a panel discussion in which **Dr. William F. Nowlin, Gary** surgeon, participated.

Dr. and Mrs. J. R. Baum Honored

A certificate in recognition of their many years of service to the Kosciusko County Red Cross was presented to **Dr. and Mrs. J. R. Baum, Winona Lake,** recently. The occasion was the visit of the Red Cross Bloodmobile and the Baums' 46th wedding anniversary.

Dr. Childress Named by ACP

Dr. Richard H. Childress, Indianapolis, has been named a Fellow of the American College of Physicians.

Dr. Kershner Named Orthopedic Fellow

At the annual meeting of the American Academy of Orthopedic Surgery in San Francisco recently, **Dr. Charles R. Kershner, Marion,** was inducted as a fellow.

New Rehabilitation Center Dr. Lytwakiwsky's Topic

Dr. Anatol Lytwakiwsky, medical director of the Rehabilitation Center of Methodist Hospital of Gary, was the guest speaker at the hospital Auxiliary's Spring Tea, where he discussed the coordination and opening of the comprehensive rehabilitation program at the hospital's soon-to-be-completed Rehabilitation Center.

Vanderburgh County Medical Society Takes Quick Action on Drain Cleaners

The Vanderburgh County Medical Society adopted a resolution in regard to liquid drain cleaners recently just five days before the FDA published a regulation on the matter. All liquid drain openers of more than 10% concentration are now banned from the market. The danger of the more concentrated liquids lies in the damage which is produced when the liquid is swallowed accidentally by children. Granular products, even though much stronger, are not as dangerous, since children will spit out the granules and spare the esophagus. FDA has found 271 cases of children ingesting liquid drain openers in the past four years. ◄

New Indiana Law Concerning A Statewide Medical Education System

HOUSE ENROLLED ACT No. 1430

AN ACT to amend the Indiana Code of 1971 by adding a new chapter, 20-12 concerning a statewide medical education system.

WHEREAS, there is a serious need throughout the state of Indiana for greater numbers of practicing physicians in allied health care professionals; and

WHEREAS, retention within the state of Indiana of those trained in health care services, particularly physicians has become increasingly more difficult; and

WHEREAS, the Indiana University School of Medicine has expanded to meet the need but finds it difficult to satisfy the ever-increasing demand for qualified persons to deliver health care services; and

WHEREAS, the public and private institutions of higher education in the community hospitals throughout the state of Indiana are capable of absorbing additional students for training in the health care services at an early date; and

WHEREAS, building a second medical school would require a delay of approximately ten (10) years before increasing the number of graduating physicians, would cost an amount exceeding the current financial capabilities of the state of Indiana and would most materially benefit one (1) limited area of the state; and

WHEREAS, multiple medical education centers will attract students, interns, and residents to the several geographic areas, thereby attracting increased numbers of practicing physicians, encouraging development of health care facilities, providing for the training of additional numbers of allied medical personnel, and increasing capabilities for the existing program of graduate and continuing medical education: Therefore,

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. I.C. 1971, Title 20, Article 12, is amended by adding a new chapter, to be numbered chapter 30.5 and to read as follows: Chapter 30.5. State Higher Education: Indiana Statewide Medical Education System Sec. 1. There is hereby established the Indiana Statewide Medical Education System.

Sec. 2. The Indiana Statewide Medical Education System shall include, but not be limited to, centers for comprehensive medical education established in cooperation with existing medical and educational institutions in Gary, Fort Wayne, Lafayette, Evansville, South Bend, Terre Haute, and Muncie, Indiana. These centers shall be known separately and respectively as Northwest Center for Medical Education at Gary, Fort Wayne Center for Medical Education, Lafayette Center for Medical Education at Purdue University, Evansville Center for Medical Education, South Bend Center for Medical Education, Terre Haute Center for Medical Education at Indiana State University, Muncie Center for Medical Education at Ball State University.

Sec. 3 A director shall be jointly appointed for each center in the system by the office of Dean of the Indiana University School of Medicine and the local cooperating institution or institutions and hold a joint appointment with the local cooperating institutions. An advisory council shall also be appointed by each local center to provide as effectively as possible for a high degree of support and advice from the lay and professional communities.

Sec. 4. The administration of the Indiana University School of Medicine shall be responsible for planning and implementing the orderly development and expansion of a medical education program in each center in cooperation with the director and staff of the cooperating institutions. Budgets for each center shall be proposed by the centers for review and approval by the Dean of the Indiana University School of Medicine, whose office shall be charged with the responsibility for fiscal administration.

Sec. 5. Joint faculty appointments shall be made by the Indiana University School of Medicine and the participating institutions of higher education.

Sec. 6. The Indiana University School of Medicine shall be responsible for selection, admission, and assignment of students, curricular development and evaluation, and accreditation.

Sec. 7. Medical students shall be admitted in 1971 to those centers which, in the judgment of the Indiana University School of Medicine, have developed appropriate faculty, facilities, and curricula consistent with the accreditation standards of the joint commission on accreditation of the American Medical Association and the Association of Medical Colleges.

Sec. 8. In order to insure continuing educational excellence, the Indiana University School of Medicine shall provide for periodic, systematic evaluation of the Indiana Statewide Medical Education System in cooperation with the Governor's Commission on Medical Education or its successor body.

SEC. 2. Whereas an emergency exists for the more immediate taking effect of this act, the same shall be in effect from and after its passage. ◀

What's New?

Technicon has a new fully automated system, Coaglab,™ which profiles coagulation defects and provides data for monitoring anticoagulant therapy. It is fast, accurate and economical. Prothrombin time and partial thromboplastin time may be measured simultaneously at the rate of 60 samples per hour, twice the speed of manual determinations. The end point is more sensitive than any other system.

* * *

A new spirometer, made by Fibre-Optics Industries, operates on the fibre-optics principle and produces a permanent record on Polaroid® film. It is called Spirostat,™ weighs but four pounds and utilizes a disposable flowmeter. This prevents exhaled organisms from entering the instrument. It will measure forced vital capacity, forced expiratory volume first second, timed vital capacity, the ratio of forced expiratory volume in the first second to forced vital capacity, mean maximum expiratory flow, maximum breathing capacity, maximum voluntary ventilation and inspiratory vital capacity.

* * *

Owens-Illinois has a new type of bottle cap which young children find difficult to remove. It incorporates a flexible inner disc which provides the tension required to keep the cap locked on the bottle. The cap must be pushed down and turned simultaneously for removal. Few children under five have the coordination required for this action. This age group suffers the most accidental drug poisonings.

* * *

The JOBST® HYDRO-FLOAT® Bed is a complete flotation therapy unit, consisting of a flotation bladder mattress which is permanently fastened to the sides of the bed which, in turn, may be raised or lowered to produce total flotation, partial flotation and no flotation. An hydraulic power assist is used to raise and lower the sides. The device is recommended for pressure sores, both for prevention and treatment. The bladder is guaranteed not to crack, split or develop pin holes, and is washable and steam autoclavable.

* * *

Parke-Davis announces a new Orthaletic Elastic Adhesive Tape. It is flesh-colored, all-cotton elastic bandage with high-quality adhesive on one side. It was devised specially for taping knees, elbows and shoulders of athletes. It has free-flow unwinding characteristics.

* * *

Doubleday has a paperback edition of "Love, Sex and Being Human." The author, Paul Bohannan, discusses the moral aspects of human sexuality with honesty and objectivity. Especially for teen-agers, parents might also benefit. 182 pages, $1.25.

BOR-LOK Products has a device which locks into any rifle, shotgun or handgun. It has a three-tumbler combination lock which fits on the end of the barrel. A rod is attached to the lock. When the lock is attached to the end of the barrel the rod extends through the barrel into the chamber. The lock cannot be applied if the chamber contains a cartridge or shell, and after the lock is applied the gun cannot be loaded. It makes the gun tamperproof and identifies it on sight as safe.

* * *

The Stryker Corporation has a new brochure to help surgeons simplify the instruments for hip arthroplasty. There is also a guide illustrating the instruments useful in hand surgery. Free copies may be obtained by writing to 420 Alcott St., Kalamazoo, Mich. 49001.

* * *

General Electric has a new surgical patient monitoring system with a four-channel scope which visualizes the ECG, arterial pressure, peripheral pulse rate and the EEG. The system also incorporates digital displays of systolic, mean, diastolic and venous pressure and heart rate. Each can be read at a glance from 15 feet. All patient cables are contained in a single cable sleeve. The system is shelf mounted on a mobile stand.

* * *

The first synthetic, chemically defined, low residue food which provides total nourishment for humans is announced by Eaton Laboratories. Called Vivonex-100, it is a balanced formula of pure amino acids, vitamins, minerals, simple carbohydrates and essential fat. It is palatable and comes in a variety of flavors, beef broth, vanilla, chocolate, grape, sharp orange and mild orange. It is figured at six packets or 1800 calories per day. May be sipped, fed with a spoon, taken with a feeding syringe or through a tube.

* * *

Labconco of Kansas City has a new bulletin which describes its line of corrosion-proof laboratory carts. There are 12 different types of carts, each with a blue electrostatically applied coating that is tougher than stainless steel or chrome. The special coating not only looks better but muffles sound better, and will not chip, peel or corrode.

* * *

Cenco Medical/Health has a new line of 5 intravenous infusion devices. The "Practi-Cath" units have a number of unique features which contribute to ease of use and safety to the patient. The split needle, the transparent teflon catheter, a "flash chamber," and an extra long contoured needle hub which is easy to grip are some of the special features.

* * *

Technicon is introducing a new instrument called "TAAS" (Technicon's Automated Antibiotic Susceptibility) system. Within three hours of introducing a sample culture into the system, complete test results of antibiotic sensitivity are available. Cultures may be screened routinely at the rate of 40 cultures per hour after the initial three-hour incubation period. ◄

Association News

EXECUTIVE COMMITTEE

June 12, 1971

The Executive Committee convened in the Headquarters office at 4:00 p.m. Saturday, June 12, on the call of the Chairman, Dr. Donald M. Kerr.

Roll call showed the following present: Donald M. Kerr, M.D., Chairman; Wilbert McIntosh, M.D.; Malcolm O. Scamahorn, M.D.; Peter R. Petrich, M.D.; Joe Dukes, M.D.; Lester H. Hoyt, M.D.; Hugh K. Thatcher, M.D.; Frank B. Ramsey, M.D.; and James A. Waggener.

MINUTES OF THE MEETING held March 27, 1971, were approved on motion of Drs. Petrich and Hoyt.

Membership Report

Membership report as of April 30, 1971 was reviewed and accepted as printed, as follows:

Number of members as of December 31, 1970	4,504
1971 members as of April 30, 1971:	
Full dues paying members	3,850
Residents and interns	63
Board remitted	46
Senior	373
Honorary	3
Military	34
Total 1971 members as of April 30, 1971	4,369
Total 1970 members as of April 30, 1970	4,396
Number of AMA members as of December 31, 1970	4,337
Number of AMA members as of April 30, 1971	4,118
Full dues paying	3,602
Exempt, but active	516
	4,118
Number who paid state dues but not AMA as of April 30, 1971	248
Number who paid state dues but not AMA as of December 31, 1970	168

Headquarters Office

FIELD REPORT ON BENTON COUNTY—The report of the field secretary on activities in Benton County was reviewed for the information of the committee.

LETTER FROM CHAMPUS—A letter from CHAMPUS praising the ISMA for its efficiency in processing CHAMPUS claims was reviewed for the information of the committee.

PHYSICIAN POPULATION REPORT—A physician population study by counties was distributed to the committee for their information.

TOURS—The action of the House of Delegates and the Board with respect to the Association conducting tours was discussed. The president-elect is going to review materials received by the secretary's office for possible recommendation to the Executive Committee and the Board.

TERM OF DR. KIRTLEY ON HANDICAPPED COMMITTEE—The expiration of Dr. James Kirtley's term on the State's Handicapped Committee was called to the attention of the committee and, on motion of Dr. McIntosh and taken by consent, Dr. Kirtley is to be recommended for reappointment.

RESOLUTIONS FOR AMA—Two proposed resolutions for presentation to the AMA dealing with substitution of drugs were reviewed and by consent these were referred to the Board of Trustees.

Treasurer's Office

The treasurer reported on the analysis of receipts and expenditures and the investment portfolio and, on motion of Dr. Hoyt, the report was approved on an informational basis with the recommendation that Dr. Hoyt and Dr. Thatcher meet with Mr. Waggener prior to the next meeting for a discussion of the method of reporting being done by the computer system. The motion was taken by consent.

The treasurer then discussed the Medical Foundation fund and the new Federal regulations and it was decided that no action be taken at this time.

Organization Matters

The replacement for the vacancy created on the Blue Shield Board by the death of Dr. G. O. Larson whose normal term will expire in March of 1972 was referred to the Board by consent.

CORRESPONDENCE WELBORN CLINIC—Correspondence between the headquarters office and the Welborn Clinic in Evansville dealing with their proposal to establish their own medical care system was reviewed and, by consent, was referred to the Board of Trustees.

VOLUNTEER PHYSICIANS FOR VIET NAM—Information from the AMA was received stating that a plaque would be forwarded with a citation for volunteer service given to the Physicians for Viet Nam Program by Leonard J. Green of Valparaiso. By consent it was agreed that this plaque would be awarded to Doctor Green at the time of the annual meeting.

CONTRIBUTIONS TO AMA-ERF—A report of the contributions to AMA ERF which showed I.U. School of Medicine receiving the largest single contribution for all medical schools in the nation was reviewed for the information of the committee.

LETTER FROM INDIANA CHAPTER OF AMERICAN COLLEGE OF SURGEONS—A letter from the Indiana Chapter of the American College of Surgeons offering their assistance in planning a Peer Review program was reviewed for the information of the committee.

FUNDING OF INDIANA PERINATAL CARE PROJECT—A letter was read from the State Board of Health announcing that they had approved the funding of the Indiana Perinatal Care Project to be conducted through the Indiana State Medical Association in the amount of $3,100 for the period May 1, 1971, through June 30, 1971, and the amount of $30,000 for the period July 1, 1971, through June 30, 1972.

LETTER FROM MRS. G. O. LARSON—A letter from Mrs. G. O. Larson expressing thanks for the thoughtfulness of the members of the association at the recent death of Dr. Larson was read for the information of the committee.

LAPORTE COUNTY MATTERS—The matters from LaPorte County Medical Society were reviewed and the item concerning legal service was discussed and by consent it was agreed that nothing should be done until such time as a formal request is received from the Society.

The letter from the LaPorte County Medical Society concerning a Medical Careers Day program was reviewed and the field secretary is to be requested to check this matter more fully.

LETTER FROM H. WM. GILLEN, M.D.—A letter addressed to the State Insurance Commissioner by Dr. H. Wm. Gillen was referred to the committee for their information and, on motion of Dr. Hoyt and taken by consent, this will be referred to the Commission on Medical Economics and Insurance.

REPORT FROM COMMISSION ON MEDICAL ECONOMICS AND INSURANCE—A letter from the Commission on Medical Economics and Insurance setting forth their opinions on the parameters for care submitted by Blue Shield and the question of paying an assistant surgeon was reviewed and by consent referred to the Board of Trustees.

LETTER FROM AMA - ACCREDITATION PROGRAM—A letter from the AMA

concerning recommendations with respect to accreditation programs was referred to the Commission on Medical Education by consent.

LETTER FROM LA. STATE MEDICAL SOCIETY—A letter from the Louisiana State Medical Society announcing their withdrawal of approval of the Council on Medical Staffs was reviewed for the information of the committee.

LETTER FROM STATE COMMISSION ON AGING—A letter from the State Commission on Aging concerning the Senior Citizens program during the State Fair was referred by consent to the Commission on Aging and the Woman's Auxiliary.

ASSETS OF INDIANA MEDICAL EDUCATION FOUNDATION—A report on the assets of the Indiana Medical Education Foundation was reviewed for the information of the committee.

LETTER FROM ILLINOIS STATE MEDICAL SOCIETY—A letter from the Illinois State Medical Society to make inquiry if ISMA would be agreeable to a joint financing of the survey as to why physicians do not stay in their respective states was reveiwed and, on motion of Dr. Scamahorn and taken by consent, the secretary was instructed to advise the Illinois State Medical Society that, while we are sympathetic, the budget at this time is not sufficient to participate in this projected program.

LETTER FROM INDIANA CHAPTER OF SAMA—A letter from the Indiana Chapter of SAMA reporting on the recent national conference of their group in St. Louis and the expenses incurred was reviewed for the information of the committee.

RESOLUTION FROM CLINTON COUNTY—A resolution from the Clinton County Medical Society was reviewed and, on motion of Dr. McIntosh and a second by Dr. Petrich, this is to be referred to the trustee involved.

LETTER FROM WELFARE DEPARTMENT—A letter from the State Welfare Department to various county directors was reviewed for the information of the committee.

VACANCIES ON AMA COUNCIL AND COMMITTEES—Vacancies to be up for filling on various AMA Councils and Committees was referred to the Board of Trustees on motion of Dr. Petrich with several recommendations as proposed by the Executive Committee.

LETTER FROM GOVERNOR'S OFFICE—A letter from the Governor's office concerning submission of recommendations for appointment to the Commission on Higher Education was reviewed for information of the committee.

The secretary explained he had sent this information to all members of the Board so that they might make recommendations from their respective districts for the Governor's consideration.

LETTER FROM BLACK EXPO '71—A letter from Black Expo '71 was reviewed for the information of the committee.

REPORT OF LOAN PROGRAM—AMA—A report from the AMA Medical Education and Research Foundation concerning their loan guarantee program was reviewed for the information of the committee and the report indicated that 38 loans had been made in Indiana totaling $47,000 for the period January 1970 through December 1970 and the total number of loans which had been made in Indiana in the period March 1962 to December 1970 totaled 1,274 in the amount of $1,452,350.

Blue Shield-Blue Cross Matters

MINUTES EXECUTIVE COMMITTEE MUTUAL HOSPITAL INSURANCE—Minutes of the Executive Committee of Mutual Hospital Insurance, Inc., held April 18th were reviewed for the information of the committee.

REPORT TO BLUE CROSS BOARD OF DIRECTORS—A report made to the Blue Cross Board of Directors by the President of Blue Cross was reviewed and, by consent, referred to the Commission on Medical Economics and Insurance.

FIELD REPORT 7th DISTRICT—A field report concerning the 7th District meeting was reviewed for the information of the committee.

LETTER FROM CARL I. FLATH—A letter from Carl I. Flath of Bethesda, Md., was read and, by consent, a copy of this letter should be sent to the Board of Health and the Department of Welfare.

LETTER FROM ALLEN COUNTY SOCIETY—A letter from the trustees of the Allen County Medical Society addressed to two local physicians concerning their position on titles XVIII and XIX was reviewed for the information of the committee.

CORRESPONDENCE BETWEEN BLUE SHIELD AND HEW—Correspondence between Blue Shield and Bureau of Health Insurance concerning the Explanation of Benefits Forms was reviewed for the information of the committee.

Annual Convention

MEMO FROM DR. FERRY—A memo concerning the payment for speakers at the annual convention was reviewed and, on motion of Dr. Scamahorn, seconded by Dr. McIntosh, this matter is to be referred to the Board of Trustees.

GUEST LIST FOR 1971 MEETING—The question of guests to be invited to the 1971 meeting was reviewed and, on motion of Dr. Petrich, seconded by Dr. McIntosh, the invitational list for the '71 meeting will be the same as '70 with the addition of the president and secretary of the West Virginia State Medical Association.

PHYSICIAN FOR FIFTY YEAR CLUB RESPONSE—The question of who would make the response for the 50 Year Club was discussed and on motion of Dr. Petrich, seconded by Dr. McIntosh the president is empowered to select the speaker.

GENERAL CONVENTION PLANS—The secretary reviewed the general convention plans and the use of the Temple for the House of Delegates and other activities was approved.

PROPOSED TUESDAY EVENING PROGRAM—A proposed Tuesday evening program was reviewed for the information of the committee.

PRIZES FOR ANNUAL MEETING—The question of awarding prizes for attendance at the '71 meeting was deferred until the next meeting.

New Business

EMPLOYMENT OF P.R. COUNSEL—The president discussed the matter of the association employing PR Counsel and the proposed cost of the service arrangements and pointed out that he personally felt if we were going to spend this sum of money we had better spend it on a full-time employee.

On motion of Dr. Scamahorn, seconded by Dr. Dukes, the question of employment of PR Counsel was defeated.

LETTER FROM DR. STONEHILL ON SURVEY RESULTS—The president read a letter from Dr. Stonehill concerning the results of the recent survey and this matter is referred to Dr. Gosman for a further report.

LETTER FROM AMERICAN LEGION—The president also presented a letter from the American Legion Department of Indiana offering the association advertising space in their convention program and, by consent, no advertisement will be purchased.

LETTER FROM FDA—Dr. Thatcher read a letter he had received from the FDA on the subject of removal of certain drugs from the market.

MARION COUNTY ACTION—The action of the Marion County Medical Society concerning their action with respect to a proposal of the Metropolitan Health

Council for a community health network was revicwed for the information of the committee.

Future Meetings

A letter announcing an HEW Briefing to be held in Chicago June 16 was read and, by consent, no representative will be sent.

Plans for the meeting of the AMA and the schedule of events together with several leters concerning candidates for various offices in the AMA were all reviewed for the information of the committee.

The AMA Committee on Community Emergency Medical Services Regional Meeting to be held in Chicago on June 29-30 was reviewed and Dr. Cleon Schauwecker was authorized to attend at ISMA expense.

For the AMA Midwest Regional Conference on Quackery to be held in Chicago on August 6th, on motion of Dr. Dukes and seconded by Dr. McIntosh, the president and president-elect were authorized to attend and invitations are also to be issued to Senator Joseph W. Harrison, Representative Robert Bales and Speaker Otis Bowen.

The AMA 17th Annual Conference of State Mental Health Representatives will be held in Chicago on September 24 and 25 and, by consent, Dr. Betty Dukes is to be requested to represent the association at association expense.

The 13th National Conference on Physicians and Schools will be held in Chicago September 30 through October 2 and it was decided no representative would be sent.

Information on the Indiana State Chamber of Commerce Board of Directors meeting to be held in French Lick October 21, 22, 23 and their annual meeting to be held in Indianapolis November 10th was read and deferred to a later time.

There being no further business the committee adjourned to meet again Saturday, August 21st. ◄

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MONTEGO BAY JAMAICA: Three bedroom, three bath villa, three servants; swimming pool; private beach; competitive rent. Nearby golf, fishing, etc. 10% off national advertised rent for ISMA members. Inquire for details: D. F. Buehner, M D., 3700 Bellemeade, Evansville, Ind. 47715.

DIRECTLY ON quiet Cocoa Beach, nearest beach to Disney World and Space Center, 3-bedroom beach house, furnished; sleeps 10; $200 per week. For info write Cypress Lodge, 105 LaRiviere Road, Cocoa Beach, Fla. 32931.

PRACTICE FOR SALE: Well established General Practice; Southern Indiana city; population 150,000; Gross $75,000; equipped with X-ray and laboratory facilities; moving to Florida; will introduce. Write Box 367, The Journal, ISMA, 3935 N. Meridian St., Indianapolis 46208.

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TO JOIN three man orthopaedic surgeons clinic in progressive, well industralized, attractive, midwest city.
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GENERAL SURGEON, Board eligible with orthopedic, gyn and GU experience; interested in a small town (2 to 20,000 population) with good hospital. Good references. Prefer solo practice; available immediately. Write Box 370, The Journal, ISMA, 3935 N. Meridian St., Indianapolis 46208.

FAMILY PRACTICE: Available immediately; modern well equipped office; will sell or lease; above average community very willing to support incoming doctor. Inquire L. D. Denton, M.D., Greentown, Indiana 46936. Telephone 628-3824 or 628-7744.

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Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be considered for display type advertising.

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First four lines: $3.00
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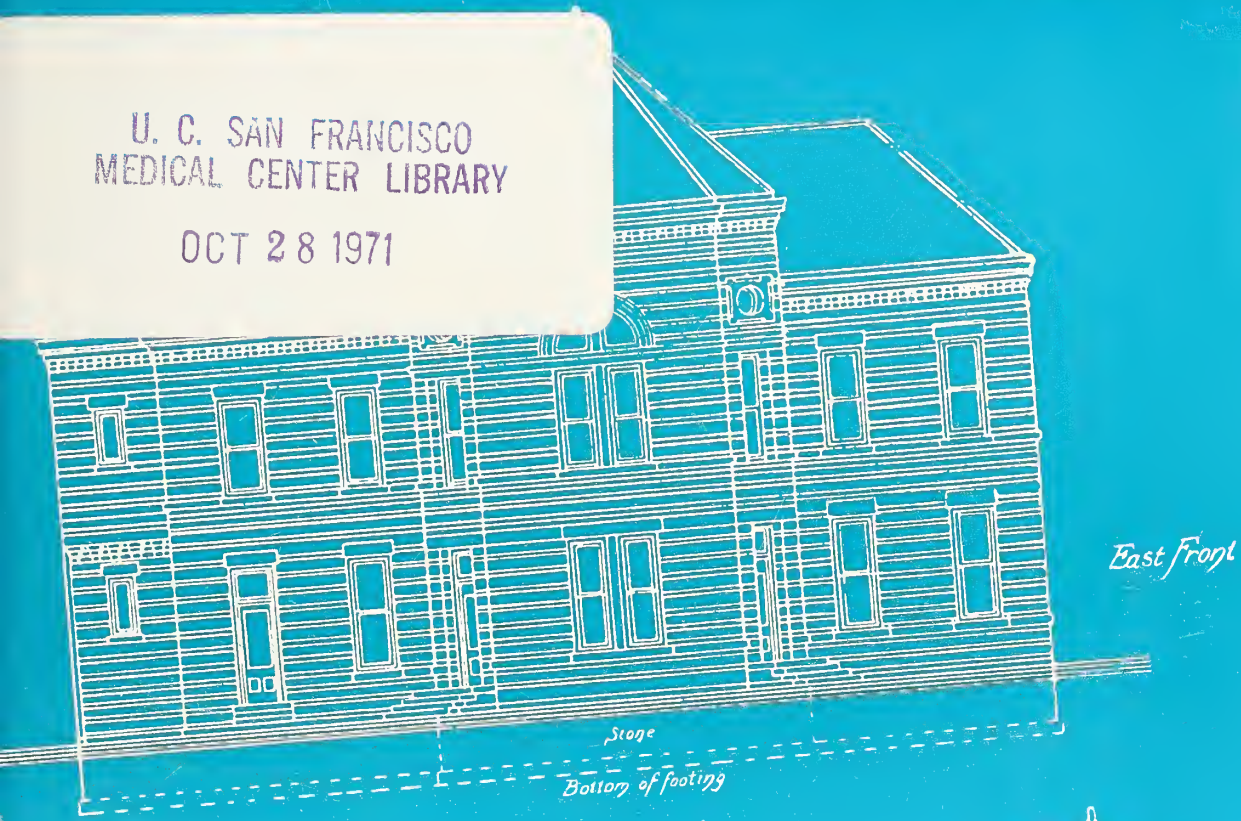
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September 1971 Vol. 64 • No. 9 • Indianapolis, Indiana

The JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION

U. C. SAN FRANCISCO
MEDICAL CENTER LIBRARY
OCT 28 1971





The Old Pathology Building

HOOSIER MEDICINE'S "LITTLE RED SCHOOL HOUSE"

Patients fell asleep quickly

Dalmane (flurazepam HCl) 30 mg reduced awake time—both before and after falling asleep - by fifty percent of pretreatment values in patients with insomnia.[1,2]

Two sleep laboratory studies recently confirmed findings of earlier studies of this type, namely, that Dalmane 30 mg was effective in patients who had trouble falling asleep, staying asleep or both. One 30-mg capsule of Dalmane usually induced sleep within 22 minutes, decreased the number of awakenings and the wake time after the onset of sleep, and provided 7 to 8 hours of sleep without need to repeat dosage during the night.

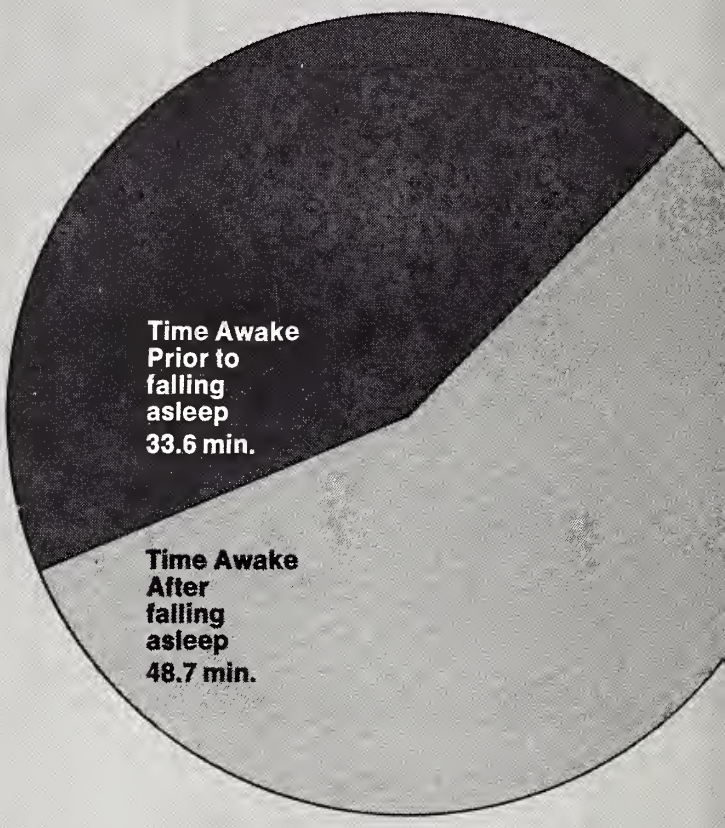
These studies utilized identical protocols and included eight insomniac patients. Sleep laboratory measurements in a limited number of patients are derived from all-night electro-encephalographic, electro-oculographic and electromyographic tracings. Unlike traditional methods of evaluation, they are quantitative, reproducible and projectable to large numbers of subjects.

Results shown represent average values in all subjects for the three consecutive nights of placebo administration prior to Dalmane therapy and the seven consecutive nights on Dalmane 30 mg.

Dalmane is also relatively safe, as reported in clinical studies. Instances of morning "hang-over" have been relatively infrequent; paradoxical reactions (excitement) and hypotension have been rare. Dizziness, drowsiness, lightheadedness and the like were the side effects noted most frequently, particularly in the elderly or debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

References: 1. Frost, J. D., Jr.: "A System for Automatically Analyzing Sleep," Scientific Exhibit presented at Clinical Convention, A.M.A., Boston, Nov. 29-Dec. 2, 1970, and Aerospace M.A., Houston, April 26-29, 1971.
2. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J.

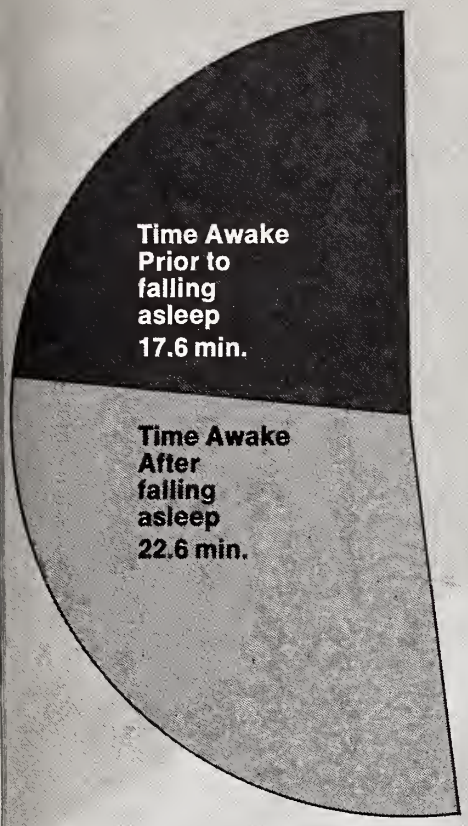
Before Dalmane (flurazepam HCl)



Measurements of sleep in the sleep laboratory are obtained with electroencephalographic, electro-oculographic and electromyographic recordings.

ıd slept through the night

On
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(flurazepam HCl)



ge sleep laboratory measurements in cited studies

neter	Before Dalmane	On Dalmane
required to fall asleep	33.6 min.	17.6 min.
time after onset of sleep	48.7 min.	22.6 min.
ber of wakeful periods after set of sleep	12.2	8.4
sleep time	420.0 min.	447.5 min.
sleep percent	88.6	94.5

nical effectiveness as
oven in the sleep laboratory

Dalmane®
urazepam HCl)

30-mg capsule h.s.—usual adult dosage.
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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

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SEPTEMBER 1971

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Office of Publication

3935 N. Meridian, Indianapolis, Indiana 46208

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3—Eli Goodman, Charlestown	Oct. 1973
4—Robert M. Reid, Columbus	Oct. 1971
5—Wilbert McIntosh, Riley	Oct. 1972
6—Stephen D. Smith, Knightstown	Oct. 1973
7—James H. Gosman, Indianapolis	Oct. 1971
7—Dwight W. Schuster, Indianapolis	Oct. 1972
8—Richard Ingram, Montpelier	Oct. 1972
9—William M. Sholty, Lafayette	Oct. 1973
10—Vincent J. Santare, Munster	Oct. 1971
11—Lowell Hillis, Logansport	Oct. 1972
12—William R. Clark, Fort Wayne	Oct. 1973
13—Otis R. Bowen, Bremen	Oct. 1971

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District	Term Expires
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2—Betty Dukes, Dugger	1971
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4—Jack E. Shields, Brownstown	1973
5—Cleon M. Schauwecker, Greencastle	1973
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7—Joseph C. Kerlin, Danville	1972
8—R. D. Williams, Anderson	1973
9—Lindley Wagner, Lafayette	1971
10—Thomas C. Tyrrell, Hammond	1972
11—James A. Harshman, Kokomo	1971
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13—G. Beach Gattman, Elkhart	1973

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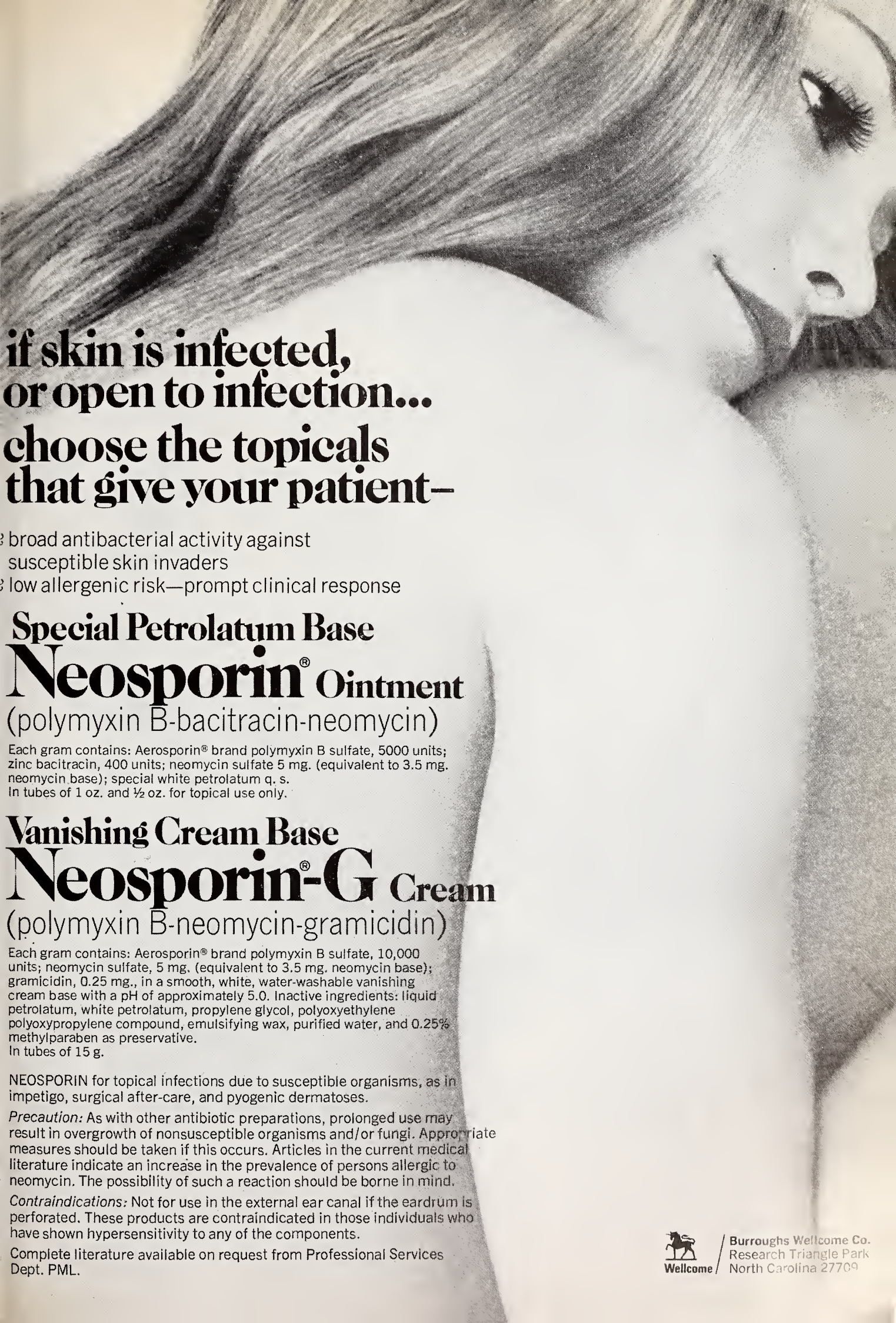
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4.	Robert O. Zink, Madison	Ott B. McAtee, Madison	May 17, 1972, Madison
5.	Burton E. Scherb, Terre Haute	James W. Cristee, Terre Haute	May 4, 1972
6.	Mark E. Smith, New Castle	James H. Tower, Jr., Shelbyville	May 3, 1972, Shelbyville
7.	John M. Records, Franklin	Merrill M. Wesemon, Franklin	June 14, 1972, Franklin
8.	Franklin K. Beeler, Anderson	Edward R. Rush, Anderson	
9.	Don W. Boyer, Lebanon	Clarence G. Kern, Lebanon	June 28, 1972, Lebanon
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11.	Lloyd L. Hill, Peru	Fred Poehler, La Fontoine	Kokomo
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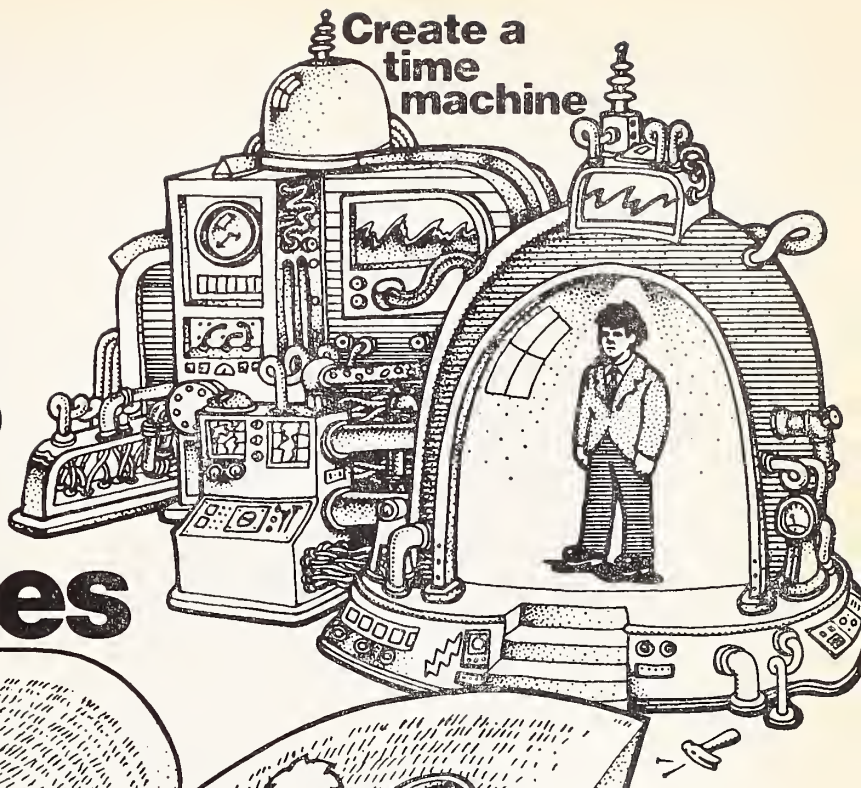
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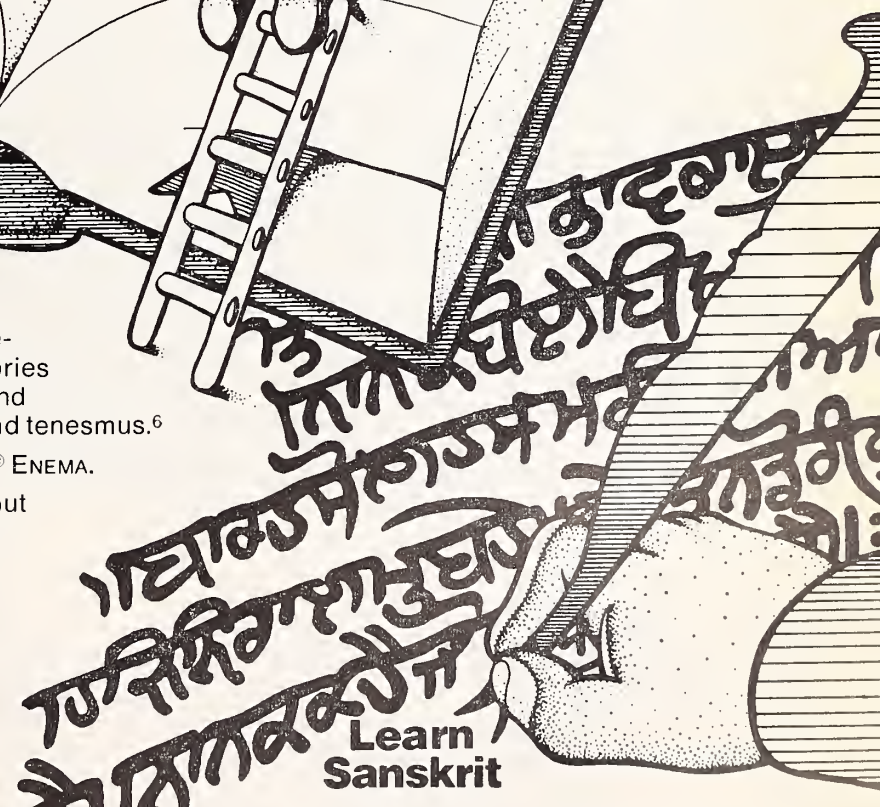
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References: 1. Blumberg, N.: Med Times 91:45, Jan., 1963. 2. Sweeney, W. J., III: Amer J Obstet Gynec 85:908, Apr. 1, 1963. 3. Weinsaft, P.: J Amer Geriat Soc 12:295, Mar., 1964. 4. Baydoun, A. B.: Amer J Obstet Gynec 85:905, Apr. 1, 1963. 5. Feder, I. A., Flores, A. and Weiss, J.: Amer J Gastroent 33:366, Mar., 1960. 6. Smith, J. J. and Schwartz, E. D.: Western J Surg 72:177, May-June, 1964.

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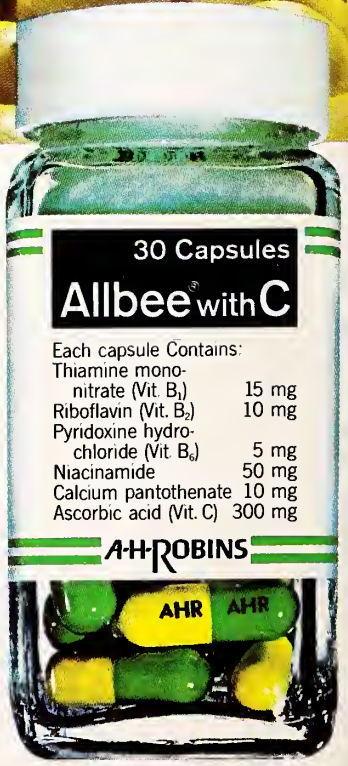


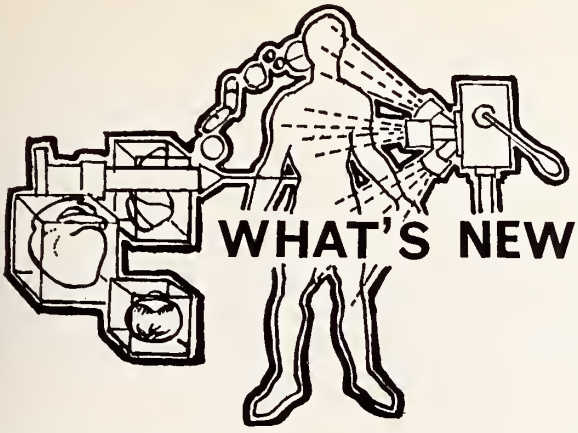
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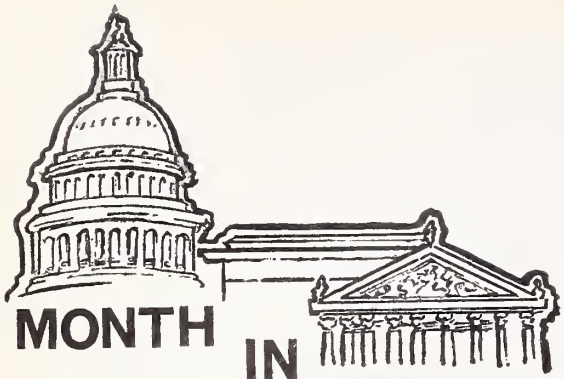
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You have to admire his undaunted spirit.



MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

THE AMERICAN MEDICAL Association supported President Nixon's legislation to create a special White House office to coordinate the federal government's fight against drug abuse "as an important element of the national campaign."

THE AMA SUPPORT was outlined by Dr. Maurice H. Seevers, chairman of the department of pharmacology at the University of Michigan and a member of the AMA Committee on Alcoholism and Drug Dependence, before the House Public Health and Environment Subcommittee. He was accompanied by Dr. Richard E. Palmer, a member of the AMA Board of Trustees.

DR. SEEVERS SAID that "under Dr. Jerome Jaffe's able direction the (White House) Special Action Office can become a most effective instrument" in achieving the purpose of the legislation: ". . . to focus the comprehensive resources of the federal government and bring them to bear on drug addiction and drug abuse with the immediate objective of promptly and significantly reducing the incidence of drug addiction and drug abuse in the nation within the shortest possible period of time."

"WE HAVE TWO additional observations regarding this stated objective," Dr. Seevers said. "First, although prompt and decisive action is to be desired as a goal, it should be clearly recognized that there are no panaceas for the prevention or successful treatment of drug dependence. Drug dependence is a complex phenomenon that does not lend itself to quick or simplistic solutions.

"OUR SECOND observation is related to that fact: Well-conceived multifaceted research is needed on a broad scale to devise effective means of coping with this problem.

"WITH RESPECT TO the drugs themselves, while much is known about their properties, relatively little is known about their precise mode of action in the human organism and the exact nature of the long-term effects of their regular use by man.

"WHILE SOME of the factors which lead individuals to abuse drugs are understood, science is not yet able to predict who may be vulnerable to drug dependence. The role of drug abuse within the context of a total life style also needs to be more clearly delineated.

"MUCH WORK REMAINS to be done in developing new, and evaluating existing, treatment methods in terms of the therapeutic needs and psy-

chosocial makeup of the individual patient. Physicians can treat the acute effects of drug abuse and drug dependence, often preventing serious physical and psychological consequences; but medical and sociological management techniques have not been developed so as to insure that a significant number of patients will not return to abuse of drugs and to their patterns of dependence after the acute symptoms have been abated through treatment.

"METHODS of 'reaching out' to the young drug abuser must be tested to ascertain the most effective courses that educators, physicians and those in other professions can pursue.

"FINALLY, a great deal more work should be carried out with human subjects. Especially needed are longitudinal studies encompassing etiology, diagnosis, treatment and after-care, even though such studies would require an extended period of years."

DR. SEEVERS CAUTIONED that "the technique of treating heroin dependence through methadone maintenance, although offering hope and the possibility of social rehabilitation to a number of dependent persons, is but one of several modalities which can be useful."

AMA'S LEGISLATIVE RECORD REVIEWED

THE AMERICAN Medical Association set forth its recent record on legislation—a record that shows statements in support of health care proposals in 31 of 35 appearances in the 91st Congress and support in the present Congress for medical school expansion, increased financial aid to medical students, family practice training programs and full funding for maternal and child care programs.

"IT REQUIRES a certain strain on the process of human logic to interpret this record as negative," the AMA stated.

THE AMA'S RECORD on legislation was submitted as part of a 39-page statement filed by the organization with the Subcommittee on Administrative Practice and Procedure of the Senate Judiciary Committee. Subcommitte Chairman Sen. Edward M. Kennedy (D.-Mass.) had charged the AMA with maintaining a negative and obstructionist attitude toward proposals to improve health care in the United States during a hearing by the subcommittee on July 14.

BILLS SUPPORTED BY the AMA in the 91st Congress included appropriations for hospital and medical facilities construction, appropriations for medical education, drug abuse education and narcotic addict rehabilitation, vaccination assistance programs and regional medical programs.

THE AMA OPPOSED as unnecessary the proposed Commission on Marihuana; opposed one version of the Occupational Safety and Health Act of 1969 but supported another version in both the Senate and House; and opposed certain parts of the Social Security Amendments of 1970 while supporting other parts of the bill.

THIS AFFIRMATIVE legislative stance has been maintained in the present Congress, as many members of the Senate and House from both sides of the aisle will attest, the AMA noted.

THE AMA, in its statement, pointed out that it has introduced its own proposal for financing health care-Medicredit-which would

provide government subsidized health insurance to the poor and insure against catastrophic medical costs.

"MEDICREDIT IS DESIGNED to end for all Americans the burden of expense, and to make all Americans truly equal in their access to all types of medical care," the AMA said.

THE ORGANIZATION WARNED against the "panacea" approach of a massive government health program as recommended by Kennedy.

"WE HAVE LEARNED that lesson in welfare and poverty," the AMA said. "Must we learn it anew with health care?"

REGARDING specific charges leveled against the organization and doctors generally by Kennedy, the AMA statement termed them "out of date, out of context, and out of balance."

"AND HIS CONCLUSION, that doctors act primarily for gain, is outrageous," the AMA report stated.

CONTRARY TO KENNEDY'S charges, the AMA noted, it does not and has not opposed vaccination programs, group practice, an increase in the number of doctors, private health insurance, government support for medical education, innovations in medical school curricula, equal opportunity in medical education or peer review.

THE AMA CITED its public record and policy statements over the years to refute these charges in detail.

THE AMA DID OBJECT to Medicare at the time of its passage because it believed available government funds should not be used to provide assistance to those who did not need it and because of the unsound actuarial basis on which it was predicated. Premiums have since had to be raised several times to support the program, the AMA noted.

AFTER MEDICARE became law, both the AMA and doctors generally gave it full support and worked to make the program a success, the statement added.

IN FURTHER RESPONSE to other testimony before the subcommittee on the same date, the AMA denied that it was responsible for "major weakening" of the proposals offered in 1964 by the Heart Disease, Cancer and Stroke Commission, which called for 60 regional clinical and care complexes.

CITING THE RECORD once again, the AMA pointed out that the legislation was hastily drawn and was submitted to Congress without sufficient supporting data. This fact was recognized and alluded to by Kennedy himself at the time, the AMA noted.

TWO OF THE commission's own subcommittees had serious reservations about the legislation, the AMA stated, and it was only after AMA officials worked in close cooperation with Johnson Administration officials that the bill was salvaged with an emphasis on pilot projects to test the theories and concepts advanced by the commission.

THE AMA COMPLETED its statement:

"LET US SET ASIDE old, worn-out charges. Let us set aside emotional language and political opportunism. Let us, instead, seek together valid and workable solutions to the health care problems that confront us.

"THE AMA WILL SUPPORT every such effort."

PROPOSES HIGHER PAY FOR PHYSICIANS IN ARMED SERVICES

DR. RICHARD S. WILBUR, new assistant defense secretary for health and environment, proposed that the military services pay physicians substantially more to avoid a severe shortage of medical skills when the services switch to an all-volunteer basis in mid-1973.

DR. WILBUR, who succeeded Dr. Rousselot in the defense department's top medical post, is on leave of absence as the American Medical Association's deputy executive vice president.

AT HIS CONFIRMATION hearing, Dr. Wilbur told the Senate Armed Services Committee that the health and environmental problems of the defense department cannot be entirely separated from those of the civilian population. Among the major problems facing Dr. Wilbur in his new post are filling the armed services' needs for physicians, drug addiction in the services and whether there should be a military medical school.

HE TOLD PENTAGON newsmen that he opposes establishment of such a school at this time. It has been a favorite project of Chairman Edward Hebert (D.-La.) of the House Armed Services Committee and Dr. Rousselot. Dr. Wilbur said he was not enthusiastic about a military medical school because it would not begin producing enough doctors to be worthwhile for many years.

DR. WILBUR PREDICTED that the military will have "a severe health care shortage when the draft is gone" unless something is done about it.

WILBUR SAID the problem boiled down to money and that experienced doctors could make much more on the outside than they do in the military. There are currently 14,500 physicians and 6,000 dentists in the services.

WILBUR SAID THE NEED was to induce doctors with eight or 10 years service to stay in the military. At present, these men leave in large numbers and the services are forced to draft young doctors whom Wilbur described as "ineffective" because they lack experience. He said the services calculated that each brand new doctor putting in 24 months in uniform actually produced only 14 months of work.

A DOCTOR with 10 years in the service now gets $350 more a month than other officers of equal rank.

WILBUR SAID to retain experienced doctors and yet convince Congress to go along with an added bonus scheme, the military might just do with fewer doctors. Under this plan, he said, the actual budget for doctors' pay would remain unchanged but the funds would be spread among fewer men. ◄

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USE IN CHILDREN. The safe and effective use of this drug in children has not been established, therefore, the physician must weigh the benefits against the potential hazards.

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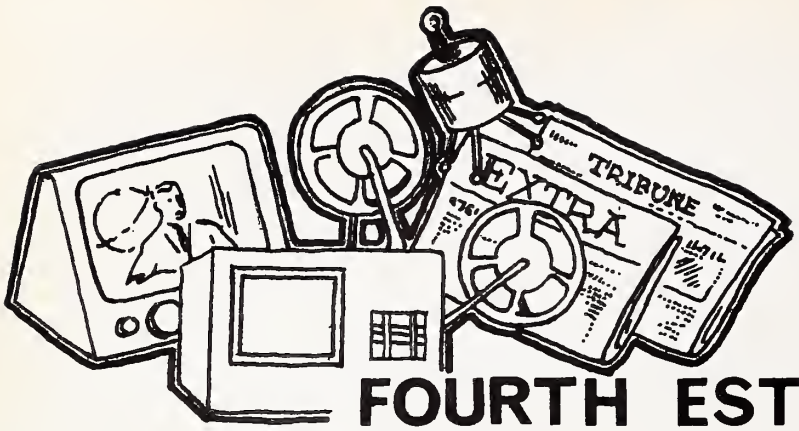
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FOURTH ESTATE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Medical Politics

The government of British Columbia's action to take over from local boards the power of granting hospital privileges to doctors is extreme and probably unworkable.

But the medical profession, which is loudly protesting the action, has little reason to be unduly surprised about it.

The government action is apparently designed to try to ensure a better balance of medical service between urban and rural areas. Whether doctors barred from big-city hospitals would migrate to less-well-served areas, however, is not at all certain. More likely, they would simply move to other Canadian cities.

Just the same, the chronic shortage of doctors in rural areas has been a very real problem throughout the country for many years and has produced considerable pressure on politicians to do something about it. And when politicians get leaned on, they act—wisely or otherwise.

The medical profession has been granted broad powers of self-government, in the public interest. But with such power goes a large measure of responsibility to the public for the provision of adequate medical services.

The urban-rural imbalance is just the sort of problem the profession should have come to grips with by now.

Doctors may argue, of course, that this is not really their problem at all and to a certain extent they are right. But if the doctors make this somebody else's problem, then they are inviting that "somebody else" (in this case, the government) to take over part of their responsibility for the provision of medical services.

And that, doctors should realize by now, has its own dangers.—*The Edmonton Journal*, Aug. 3, 1971.

New Hope Realized

When Nachon H. Keljik first began talking about his dream, not quite three years ago, a lot of people knowledgeable in the field of dealing with the needs of the severely handicapped thought he had a pipe dream.

Now the first physical facility of the New Hope Foundation is under construction on the far Northwest-side. Completion of the initial unit is scheduled 14 months hence.

New Hope's goal is a nation-wide network of free-enterprise, essentially self-sustaining full-service residential, health-care and activities centers for the severely handicapped. No such facilities now exist on anything approaching the envisioned scale of breadth of services. There was no precedent for the ingenious system of insurance-based financing the officers of New Hope devised.

The primary purpose is to guarantee care for persons so handicapped that they cannot sustain or care for themselves, after their breadwinners have died or become too ill or infirm to care for them. The centers, when fully developed, also will offer all manner of services, on a fee basis, for all handicapped persons.

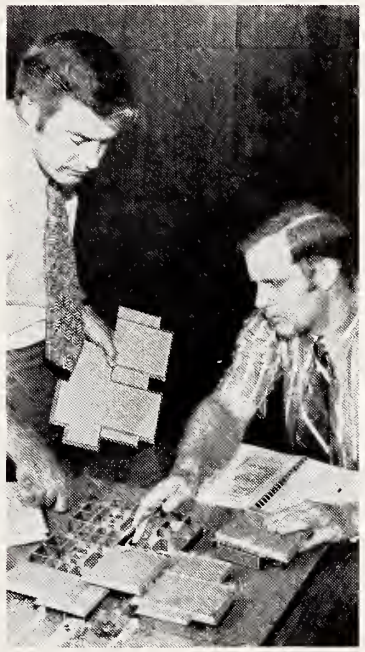
Basic funding is from monthly payments by families of handicapped persons who will be the ultimate beneficiaries. Friends and philanthropists, both individuals and other foundations, have helped. Eventually investment income is expected to help sustain the operation.

New Hope has tackled—and now shows promise of succeeding in—a job of the sort too many Americans are inclined to say only government can do. We salute its founders, who have shown enterprise and daring of the good old-fashioned American stripe, and wish their venture every success.—*The Indianapolis Star*, August 8, 1971. ◄

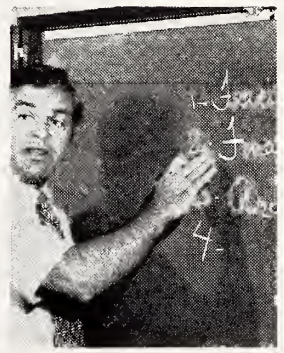
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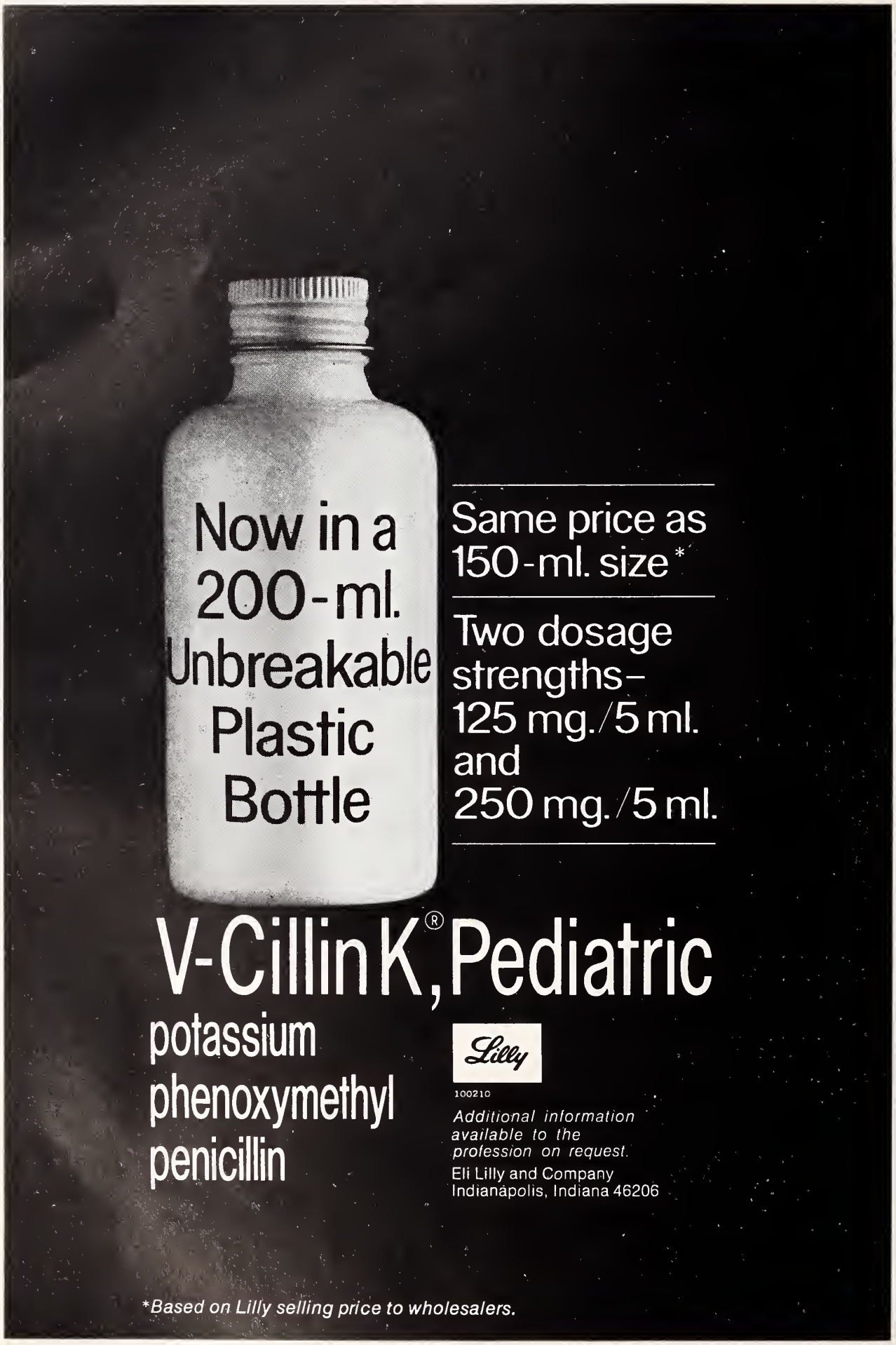
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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Volume 64 — September 1971 — Number 9

The Old Pathology Building—Hoosier Medicine's "Little Red Schoolhouse"

CHARLES A. BONSETT, M.D.
Indianapolis

IN an era when "little red schoolhouses" dotted the Hoosier countryside and the horse-and-buggy provided the principal means of transportation, a very special "little red schoolhouse" was built on the grounds of what was then known as the Central Indiana Hospital for the Insane. This unique little red brick building wasn't called a schoolhouse because it had a more imposing title of Pathological Department; and it had been conceived in even grander scope to be Indiana's first medical center. But schoolhouse it was, and schoolhouse it will continue to be in the memories of those Hoosier physicians who recall their own student days in the amphitheater of this venerable 19th Century landmark.



DR. George F. Edenharter, the superintendent of the Central Indiana Hospital for the Insane. Dr. Edenharter designed the Old Pathology Building to be Indiana's first "Medical Center."

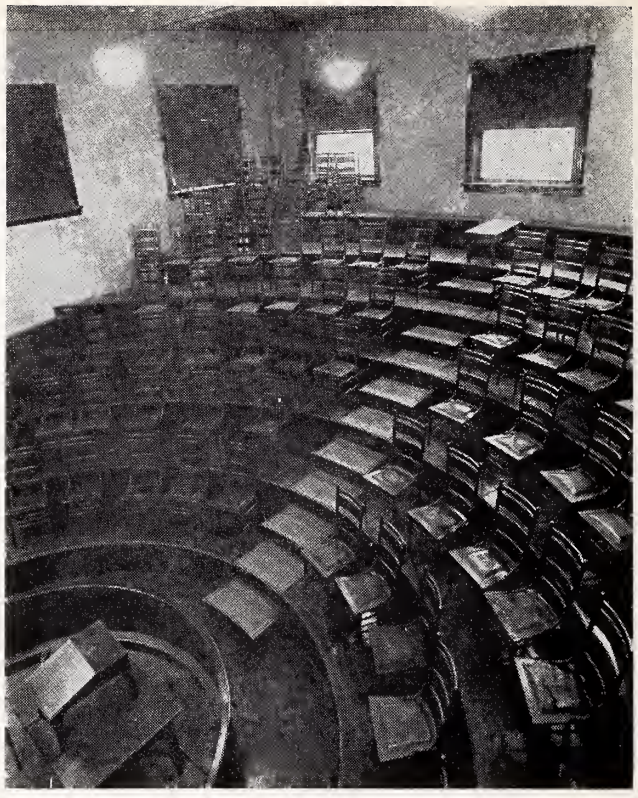
In the beginning the amphitheater was used by the Medical College of Indiana and the Central College of Physicians and Surgeons, both proprietary schools located in Indianapolis. In 1905 these two schools joined with the Fort Wayne Medical College to form a single Medical School under state supervision and support. The combined facilities were originally a part of Purdue University and were known as the Indiana Medical College, Department of Medicine, Purdue University. At this time yet another medical school, known as State Medical College, was started in Indianapolis. In 1908 all of these schools were united with Indiana University, the name then becoming the Indiana University School of Medicine.

Throughout this entire period the Old Pathology Building provided the neurology and psychiatry for all of these schools, and it continued to serve Indiana University School of Medicine in this capacity until 1955.

The Old Pathology Building was the brainchild of Dr. George F. Edenharter, who was an 1886 graduate of the Medical College of Indiana. Dr. Edenharter's forte was medical administration. He became superintendent of City Hospital in Indianapolis soon after his graduation and was later appointed superintendent of the Central Indiana Hospital for the Insane (now Central State Hospital) in 1893. With the well-known histologist, Dr. Ira van Gieson, as consultant and Adolf Scherer, a local architect, Dr. Edenharter designed a very practical two-story laboratory structure, which he conceived to be a "Medical Center" to be used primarily for original research into nervous and mental disorders but additionally was conceived to be used by physicians and students throughout the State who could benefit from the teaching and laboratory facilities. Dr. Edenharter brought the financial resources of the state to bear upon the evermounting problem being faced by the proprietary medical schools — that of providing adequate laboratory facilities. The building contained a room for anatomical dissection (before Indiana had an anatomical law). Facilities were present for gross pathology, histology, bacteriology and clinical chemistry. Dr. Eden-



THE "Amphitheater" of the Old Pathology Building during the early years of Indiana University School of Medicine. Figure in right foreground is Dr. Charles Neu.



THE "Amphitheater" today. The same chairs are empty. Paint and plaster are peeling from the walls. (Photograph courtesy of John P. May.)

harter provided the best of what 19th century medicine had to offer. He took the initiative to build this building as it should be built, without benefit of committee or quality-sacrificing bids. The building was (and still is) of sound construction and was furnished throughout "first-rate."

The building still stands, now empty, quiet, and unused. The roof leaks. Plaster is falling from the ceiling. Paint is peeling from the walls. Except for these minor signs of age and use, the building is yet capable of further service. It has never been modernized. Its large amphitheater still has the original 160 uncomfortable chairs arranged in concentric tiers around a central podium, where generations of Hoosier medical students received their instruction in neurology and psychiatry.

In the beginning the teacher at the podium was Dr. William Baldwin Fletcher, a wise and venerated old man, who taught here in the ten years preceding his death. Dr. Fletcher, along with Dr. John Bobbs and others, had been one of the original founders of the Indiana Medical College (in 1869), the oldest of the medical schools providing the root stock from which Indiana University School of Medicine later developed. On the occasion of Fletcher's death in 1906, his good friend, James Whitcomb Riley, penned a poem in eulogy, entitled "The Doctor."

Other physician teachers, including Dr. Albert E. Sterne (founder of Norways Sanitarium), Dr. Charles Neu, Dr. Frank Hutchins, Dr. Max Bahr, Dr. Larue Carter, Dr. Walther Bruetsch, and others taught here. The last teacher, and perhaps the best remembered by living Hoosier physicians, is Dr. Walther Bruetsch.*

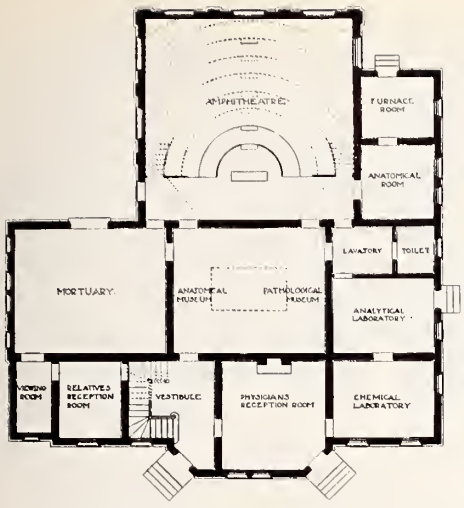
Dr. Fletcher and Dr. Bruetsch had similar histories. Both received their specialized training in Germany. Both served their countries in time of war (Fletcher with the Union Army during the Civil War; Bruetsch with the German Army during World War I). Both were captured by the enemy, and both were wounded. Both, as a result of their wounds, had personal contact with a notable figure of the times (Fletcher with General Robert E. Lee, and Bruetsch with Dr. Joseph Babinski). (Fletcher served as a spy in the Union Army. He was captured and sentenced to death. He was bayoneted while attempting to escape and, while recovering from his wounds, was temporarily reprieved by General Lee.)

(Dr. Bruetsch was wounded on the Western Front. He received a wound to the spine, with resulting paralysis of his lower extremities. He was captured by the French in this condition and evacuated to a rear echelon hospital, where he came under the care of the noted French neurologist, Babinski.) Both Fletcher and Bruetsch recovered from their injuries and lived to serve their chosen profession of neurological medicine with great distinction.

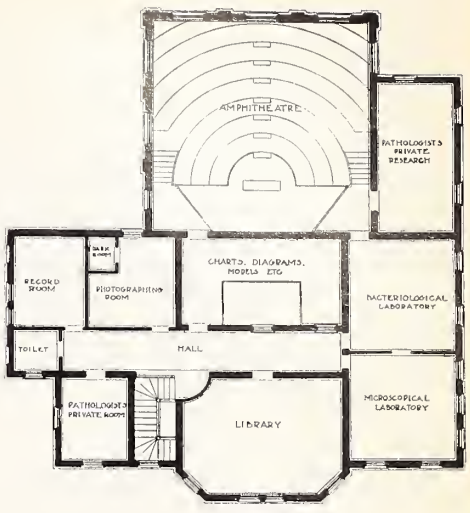
Fletcher and Bruetsch were both excellent teachers. With a little imagination their voices can still be heard in the old amphitheater, where they effectively passed along their store of knowledge to younger physicians.

The building was originally dedicated by the Marion County Medical Society on December 18, 1896. His-

* Now retired and living in Santa Barbara, California.



FIRST-FLOOR plan of the Old Pathology Building. Area marked "Viewing Room" is now used for EEG Laboratory. Area marked "Anatomical Room" and "Furnace Room" is now used for muscular dystrophy research.



SECOND-FLOOR plan of Old Pathology Building. Current renovation is with the "Library."

tory will repeat itself on Sunday, October 10, 1971 (4:00 - 6:00 p.m.), at which time the building will be rededicated by the Marion County Medical Society in a joint meeting with the John Shaw Billings History of Medicine Society. The building is being rededicated as a museum for the History of Medicine and Medical Education in Indiana.

As it now stands, the building is itself a museum in terms of its architecture, its medical equipment, and its own long association with medical education. In addition to the items originally associated with the building, however, the building itself will be used to store and display items and books relating to Indiana medicine and Indiana medical education, these items having yet to be found, collected, donated, bought or otherwise acquired. The library, which already contains a fine collection of historical books, is to be augmented by collecting books of significance relating to the history of medicine in Indiana and to the history of neurology and psychiatry. With regard to this latter function, $25,000 of the Dr. E. Vernon Hahn bequest has been donated to the Indiana Medical History Foundation by the Indiana Neuropsychiatric Association. Other groups which have endorsed the goals of the Indiana Medical History Foundation include the Indiana State Medical Association, the Marion County Medical Society, the Indiana University School of Medicine, the Indiana Neurological Society and the John Shaw Billings History of Medicine Society. The physicians participating in this project are in private practice, as well as university-based. Indeed, one does not need to be a physician to be an active participant in the John Shaw Billings History of Medicine Society nor in its adopted adjunct, the Indiana Medical History Foundation, Inc. The cooperation and membership of any interested person is welcomed.

Although the Old Pathology Building is state-owned, it merits minimal maintenance only under existing budgetary restrictions. In order for the building to be preserved, it will require additional sources of income. Governor Edgar Whitcomb has granted state permission for private funds to be spent in behalf of the building. The Indiana Medical History Foundation, Inc., was established as a not-for-profit corporation to be the legal vehicle to achieve this end. The Foundation now serves as a curatorial adjunct to the John Shaw



THE "Vestibule," looking into the "Physician's Reception Room" and the "Chemical Laboratory." The "Museum" is to the left. The pipe in the ceiling is a remnant from the days of gas illumination. (Photograph courtesy of John P. May.)



THE "Microscopical Laboratory." Circular hardwood cabinets are a feature of three of the laboratories. Dr. Walter Bruetsch wrote many of his scientific papers in this room. (Photograph courtesy of John P. May.)

Billings History of Medicine Society.

In order for the building to be preserved, it must also be staffed and utilized in some type of ongoing contemporary program. This has been achieved in two ways in this building. A corner room, which was originally designated as "viewing room" now serves as the EEG Laboratory for Central State Hospital. The area originally designated as the "furnace room" and "anatomical room" has been converted to a modern laboratory for the Indiana Neuromuscular Research Laboratory, a unit of the Marion County Muscular Dystrophy Foundation. This latter area was used for storage only. Neither of these contemporary services detract from the 19th Century atmosphere of the building. Both areas are isolated from the building's normal traffic pattern. The funds for converting the storage area into a Muscular Dystrophy Laboratory were donated. $2,500 was provided by the Marion County Muscular Dystrophy Foundation, and $5,000 was donated by an interested and generous citizen, who chooses to remain anonymous.

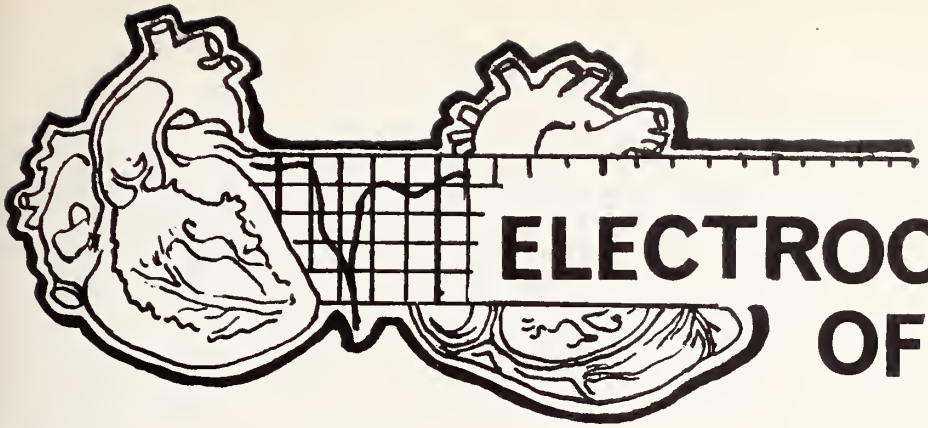
The building is of national interest also. It was designated as one of the few old Indianapolis buildings which should be preserved, by Mr. James Massey of the Department of the Interior, when he toured the country several years ago in an effort to prevent the destruction of significant American architectural landmarks by urban renewal programs. The Old Pathology Building has subsequently been included in the Historic American Buildings Inventory Survey and is currently being studied for inclusion in the National Register of the Department of the Interior.

There are relatively few physicians actively concerned with this project at the present time. There are many physicians in the State of Indiana, however, who have an interest in our medical history, who could be of service in one way or another in gathering, preserving, and otherwise being a part of the John Shaw Billings History of Medicine Society and the Indiana Medical History Foundation. This article, in addition to being generally informative, is also meant to be an invitation to these physicians to join us in our efforts. The welcome mat of the Old Pathology Building is out and the door is open for all who are interested in participation. The welcome mat is also out and the door is open wide for all who want to be present at the rededication of the Old Pathology Building on Sunday, October 10, from 4:00 to 6:00 p.m. ◄

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THE Old Pathology Building as it appeared at the time of its completion in 1895.



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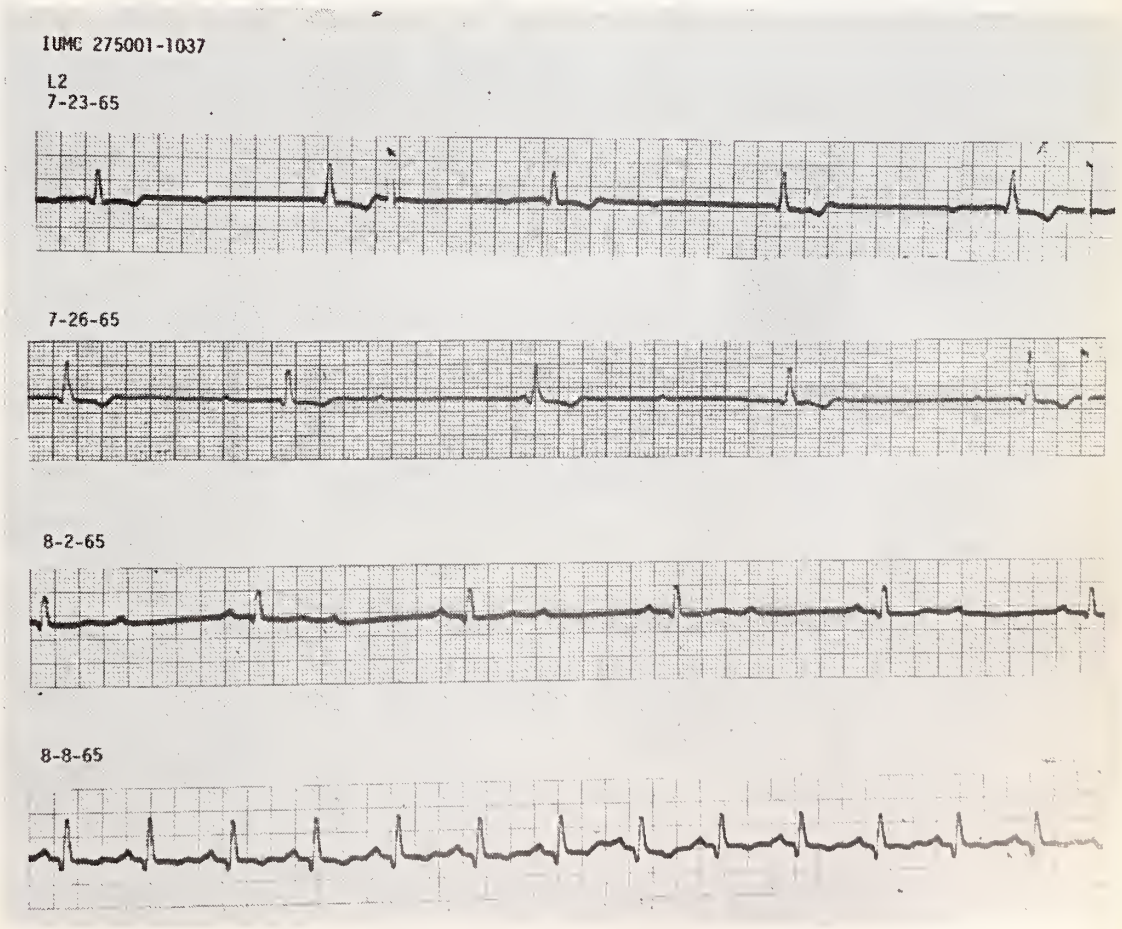
CHARLES FISCH, M.D.

*Indianapolis**

VARIOUS A-V conduction delays have been ascribed to, and actually induced by, digitalis in the experimental animal and by accident in the patient. In spite of the frequency of conduction defects induced by digitalis, in our experience third degree or complete block is quite rare. In a series of 661 patients who were considered to have digitalis intoxication, 37 (5.6%) exhibited third degree A-V block. One must realize that these studies were retrospective and thus subject to error. It may well be that the incidence of complete A-V block actually due to digitalis is less than 5.6% would suggest.

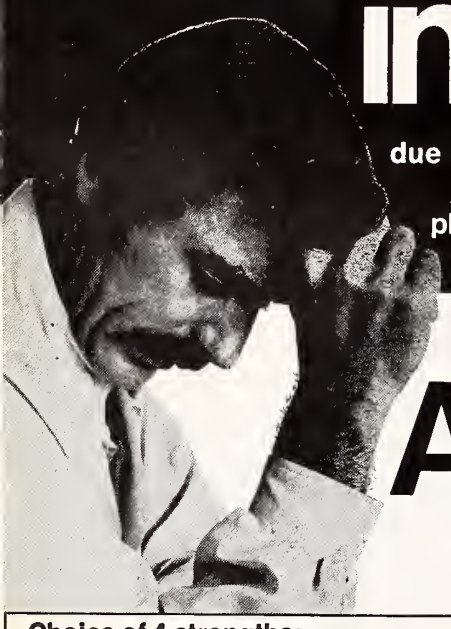
The accompanying figure was obtained from a patient intoxicated

* From the Krannert Institute of Cardiology, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis 46202.



COMPLETE A-V block due to digitalis. For details, see text.

with digitalis. On 7-23-65 complete A-V block is present with a ventricular rate of about 30 and atrial rate of about 50 per minute. The P waves are inverted suggesting A-V nodal origin due to suppression of the sinus node by the digitalis. The tracing is essentially unchanged on 7-26-65, except that the P waves are now upright indicating their normal sinus origin. On 8-2-65 there is a second degree block with a 2:1 atrioventricular response. A normal sinus rhythm was recorded on 8-8-65, 16 days after the heart block was first recorded. ◄



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References: 1. **Montesano, P., and Evangelista, I.** Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. **Dublin, M. F.** Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. **Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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In his daily practice the physician witnesses the human suffering caused by uncontrolled fertility. Perhaps one of its most tragic effects is the unwanted child, who so often experiences parental rejection. The rejected child in a family may be neglected, nagged and severely punished. Sometimes he is criminally abused. Child abuse is common enough to have become a separate clinical entity: the "battered child" syndrome. Reliable statistics are difficult to obtain, but it has been estimated that in this country alone roughly 10,000 children are "battered" per year, and their number may be increasing.

A revealing picture of child abuse patterns is provided by one study of the American Humane Society. More than half of the 662 children involved (all reported in newspapers within a single year) were less than 4 years of age. One fourth of the battered youngsters died; most of these deaths were of children less than 2 years of age. Fathers were more often guilty of child abuse than mothers, but sometimes both parents participated. The study indicated that battered children are not limited to any particular socioeconomic stratum.

***For the complete brochure, and others in the series as they appear, please write to Searle or ask your Searle representative.** Explored in the forthcoming issues will be the history of birth control, the influence of poverty, ethnic factors and marital status, its role in illness, its genetic implications and its effects on the emotional and behavioral life of the individual.

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Actions—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

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Malpractice Insurance Plan Announced

THE problems of medical professional liability insurance have been approaching crisis proportions the last few years. In July the American Medical Association and its insurance counselors announced a plan which promises to ease the cost of and increase the availability of reliable insurance.

"The program ties liability insurance to peer review by local medical societies and calls for a major effort to eliminate the causes of claims and discourage expensive litigation."

Participating medical societies must agree to remain in the program for a five-year period. Rates will be adjusted up or down during the course of the program, depending on experience trends.

The CNA Financial Corporation of Chicago will be the insuring company. Marsh and McLennan of Chicago will coordinate the various local programs as consultant to the AMA.

The new program will not interfere with group insurance plans the state societies have in operation in 24 states.

CNA intends to make 75% of the gross premuim dollar available for claims and claim expenses on the average, in contrast to the 55 to 60% of most liability policies. These economies will be possible due to mass marketing and to computerization.

Principal objectives of the new program are:

To reduce frequency of claims.

To alert doctors to ways of eliminating the causes of claims.

To resist unfounded claims.

To resolve legitimate claims promptly and fairly.

To provide doctors with long-term financial protection at fair and realistic rates.

To research alternate methods of reparation for medical injuries.

Dr. Carl Hoffman, president elect of the AMA and chairman of the Committee on Professional Liability, has said that the program is a vital part of the "total attack" on the malpractice problem. Other elements in the attack must be, he said, legislative relief and reduction of the incidents that lead to liability lawsuits.

Guest Editorials

The County Medical Society . . . for Better or Worse

MARRIAGE vows are more closely related to physicians and their organizations than it might seem. Even in these casual times, most people know that marriage is good and worth preserving.

When living together is difficult, they try to work things out and most of the time they succeed.

Many other couples split up at the first disagreement; they "cop out." That term originated among the criminal element; although it has entered somewhat better circles, it retains its crisp flavor of contempt.

The line in the marriage ceremony which says, ". . . for better or worse, . . ." might easily say, "I will not cop out; instead I will work to improve things."

Physicians are wedded to their profession probably more than any others. Unfortunately, as far as county medical societies go, too many physicians have gone home to mother; on the way out they blamed everything on mother-in-law and literally cast their professional fate to the care of others.

Does that sound incredible? It is, but it is true.

It is time to quit griping and blaming all our problems on the AMA and get out and do something on the local level.

Our levels of representation follow precisely the levels of government—national, state and local.

Nationally, the AMA is doing a

pretty good job of looking out for medical and public health interests. For example, more than one-fourth of the Congress has joined forces with the AMA to back Medicredit. Compare that with Washington's attitude toward organized medicine just a few years ago.

On the state level, constituent state associations also look out for medical and public health interests.

The nitty-gritty of it all is at the local level where the county medical society has the biggest job. Why? Because people do not live at the national or state level; they live at the local level.

The militant cry, "Power to the people," is not relevant because the people already have the power. Decisions may well be made in Washington, but the people who vote at the local level have the power to determine who shall do the deciding.

The people are not the health care critics. The people are the ones who responded to a Harris poll several months ago, and 78% of them said, "I have a higher regard for my doctor than nearly anyone else I deal with." Naturally they had some gripes too, but their regard is a remarkable compliment and it indicates how much our opinions really can mean in our communities.

Only one organization—the county medical society—is best suited as the continuing, professional assembly of physicians and also as a link between the profession and the public. The AMA's structure is one of strength and authority moving from the bottom up. The input from its 1,910 county and other affiliated societies is what holds up the AMA in Chicago.

But, to tell it like it is, with too many county societies today attendance is poor; participation in activities is limited; programs appealing to a majority of members are difficult to design; doctors say they are too busy to get involved; and the society is too small to afford a staff or even a headquarters. It struggles to maintain existence, let alone support and carry out a major constructive role.

Less than 5% of American physicians work in organized medicine—"let George do it" is the attitude of the other 95%. Well, we have come dangerously close to letting the "George" Meanys do it in health care. A lone physician cannot deal with all the financing mechanisms, legislation, and other nonscientific aspects of his profession.

Despite what many physicians have been led to believe, organized medicine does serve mankind—which often is served only by accident, whim, or through duress—because it is free to do so.

Suppose we did do away with the AMA and state and county societies, and replaced them with something like the Public Health Service and its local health departments, or committees.

Suppose your local health officer was an excellent health administrator, a veritable saint.

And suppose he was too conscientious to curry favor with local political leaders, or to award that hospital contract to the big wheel's brother-in-law.

Farewell to the saint!

Leaving anything up to politicians is risky. Health is popular this year, but next year Americans may tell their legislators, "I'm not sick; I'm out of work. Forget national health insurance and vote for anything that will make jobs." Health is out, and job-producing programs are in.

You doubt? Look at Medicare. It was supposed to help old people who have long hospitalizations. Now, bipartisan movement is under way to cut it back, and one proposal is to cut the number of fully-paid hospital days from 59 to 14.

But that's politics. Out of the legislative arena comes much that is good and logical, and also much that is bad and illogical because it results from whim and emotion instead of cool thinking.

The AMA is not affected by votes, and thus it can assess needs and try to meet them in a sound manner. This is organized medical action on a national level.

Local authorities also respond to numbers of people, organization, and a united front; here, too, strength is necessary for effective medical action.

The county medical society can provide strength; it also can provide communication between medicine and the public. People appreciate it when they can call a county society and be referred to a physician, or find out which doctors are available for emergency house calls.

The new media appreciate it when medicine communicates with them. They like to run stories about good medical care, and most reporters try hard to get authoritative information. But what if there is no one to call? What if their only contact with organized medicine is a critical letter to the editor about something called "yellow journalism"?

Communication takes many forms. A while back, ten senior medical students visited AMA headquarters. Openly hostile from the outset, they rejected the formal program that had been planned for them. Instead, they shot questions at staff members for hours. The students left not only satisfied that the AMA is dedicated to its stated purpose, but also convinced that if the AMA has faults, the students had an obligation to work within organized medicine for its betterment.

It is a pity that some physicians ignore or even scorn membership in the AMA and its state and county societies. Diversity of views among doctors is hardly surprising, and it does not detract from the value of a professional association. The organizations exist for the MD, and the setting in which one practices neither divests him of his title of physician nor eliminates his interests as a physician.

Restrictions on one type of practice will be felt in others. Suppose,

for example, that a solo practitioner also holds a teaching post at a medical school, and that some legislative measure forced him to give up one or the other? Or suppose enthusiasm for some new or newly popular aspect of medicine led legislators to underestimate the need to help medical schools financially and fewer physicians could be trained? In many situations that seem to affect only one physician group, reverberations inevitably will be felt by others.

Dr. Joseph Ichter, Doylestown, Pa., recently summarized the situation well in the *Bucks County Medical Monthly:* "The county, state and national medical associations are the only existing organizations that have the people, know-how and prestige to represent all physicians . . . (and) the only way they can be assured that they represent all physicians is if all physicians participate actively in these associations."

I have some suggestions for county society officers and members:

1. Recruit members. Lay it on the line to prospects about how their interests are tied up with your interest and with the national interest.

2. Choose responsible and diligent officers and then support them. Attend meetings, and schedule them to suit the wishes of the majority. Plan good programs. And set realistic dues in line with those of other groups. (That's one thing we can learn from the chiropractors; they have paid enough to achieve licenses and a high degree of credibility for a cult that is laughable at best and tragic at worst.)

3. Set up committees and serve them. If your society can't afford a staff, pool your resources with other societies and hire a joint staff.

4. If you possibly can, get a headquarters. And do not be miserly about it. Even a small place of your own with your county medical society's sign on the door is a worthwhile investment.

In recent years there has been a national antagonism toward organized medicine. Many physicians have contributed to it through neglect or outright criticism. Some have silently walked away.

Are all these cop-outs really disdainful of organized medicine, or are they just ducking responsibility?

Back when American medicine really smelled to high Heaven with the quacks and nostrum vendors, physicians did not take a disdainful sniff and run out. They worked to change things, and they scucceeded. One of the biggest things they did was to found the American Medical Association on May 5, 1847.

Every day, the physician's patients trust him to be right in decisions that literally mean life or death.

Ask your non-society-member colleagues, "Are you going to accept that patient's trust, do the best you can for him, and then sit back and let some politician plan his future health care? Are you going to let someone else plan your destiny too?

"Don't tell me you are too busy, and do not try to play one side against the other.

"We are all physicians; let us work together."—Edward J. Kowalewski, M.D., Akron, Pa., *Texas Medicine*, **Reprinted with permission.**

Welfare Bill Contains Seeds of Destruction

THE country faces a different world today from what we faced 25 years ago. Rapid and very deep changes within and without have created many uncertainties.

The postwar era of total American industrial and technological supremacy has yielded to a period of intensifying competition.

Another major change to be confronted is that inflation has become a chronic problem with us.

Finally, we Americans have not yet faced the fact that a price must be paid for improvements in the environment and in the quality of life that we are demanding.

We continue to escalate our demands on government with no thought of the cost. Consequently, recent estimates of the federal budget deficit for fiscal 1972 run as high as $30 billion.

Even more disturbing, projections of *existing* federal programs to the year 1975 show that these programs alone will require nearly all of the increase in the gross national product expected by that date.

And yet, against this background, the House of Representatives has just passed H.R. 1—with the so-called "family assistance plan." This bill calls for a guaranteed income of $2,400 a year for a family of four to start with. Already forces are at work to increase that allowance to $6,500, which would cover half the population and cost $75 billion a year.

As if that isn't bad enough, H.R. 1 also provides for automatic increases in Social Security benefits based upon increases in the cost of living. By 1980, the proposed Social Security taxes would be 95% greater than those under the present law, and the combined tax of $2,086.80 would represent an increase over this year's tax of 157%.

Within this one bill is the potential to destroy our private economy as we know it today.

The conclusion is inescapable: We must either reduce our demands on government or accept higher taxes. But, so far, we have chosen to postpone the day of reckoning by borrowing from the future to finance our profligate spending in the present. While this technique may buy time, it guarantees a most painful final awakening.—**Archie K. Davis, President Chamber of Commerce of the United States.**

Don't Just Sit There

DELIVERY of medical care to the poor, in both urban and rural areas in the United States, is a topic that is frequently discussed. Major attention has been directed toward urban poverty, presumably because it is more readily visible and because

it occurs in areas where the associated problems of crime, rioting and disease are so prevalent.

After listening to various politicians, social scientists, clergymen and other "do gooders" including some of our own medical profession, it is refreshing to read a slightly different version of the reasons for urban poverty by someone who has carefully studied the problem. Professor Edward C. Banfield of Harvard University is the author of a recent book entitled *The Unheavenly City*. The major thesis which runs through this book concerns the fact that the chief characteristic of the poor in these areas is their overwhelming concern with only the present. This is in sharp contrast to the "future orientation" of the middle and upper classes who have abandoned the central city ghettos for better living in high-rise apartments or in the suburbs. According to Banfield, the poverty culture to which the poor have been exposed for a lifetime does not allow for concern about tomorrow, much less for months or years in the future.

Not all poor people possess this "lower class" culture. Some by reason of illness, disability, age, and economic reverses have become unable to support themselves in adequate circumstances. In spite of their future oriented culture, they have not succeeded in making themselves economically independent. Since such persons merely lack sufficient funds, after these are supplied they are able to solve their own problems with a minimum of assistance. The hard core poverty groups, oriented only to the present, constitute an entirely different population. No amount of financial handouts will enable them to solve their problems. Financial aid, whether through negative income taxes, increased welfare benefits by racial flat rates or special allotments or any other method will be spent improvidently on useless or even harmful items.

Banfield suggests that we will not make progress in solving the problems of poverty until we recognize the futility of most of the measures which have been and still are being advocated. Such measures almost invariably are devised by people who themselves are future oriented. They are successful only when applied to the small group of poor who are also future oriented and who are poor by reason of misfortune rather than improvidence.

Planners of medical programs would do well to consider seriously the views contained in Banfield's book. Millions of dollars have been and are being expended on programs to improve the health of the urban city poor. What impact this money will have is still unknown. The probability of any real benefit is very low. In a "present oriented" society, only those medical problems which adversely affect the individual's life in the immediate present are recognized. Medical attention is sought only for serious acute illness or advanced disease. Efforts to encourage medical care for early minimal symptomatology or presymptomatic disease are doomed to failure since such efforts require that the people toward whom the effort is directed be sufficiently future oriented to see the value of the effort.

Preventive medicine which calls for any degree of individual cooperation is even more likely to fail. How can those individuals who are unable to see past the next 24 hours be expected to change their way of life for a possible benefit in disease reduction many years hence? Thus, such programs as antismoking campaigns to reduce the incidence of lung cancer, dietary manipulation to provide control of diabetes mellitus or excess weight, alcohol and drug addiction are not likely to benefit the patient or reward the physician for his efforts.

Realistically, the provision of personnel and facilities for episodic care of acute illness and exacerbation of chronic illness and preventive disease programs dependent on only minimal cooperation of the patient (e.g., willingness to be vaccinated for measles and smallpox) are about as far as we can go in attacking this problem. The development of a National Health Service Corps (S-4106) for which *Massachusetts Physician* has urged support (Oct. 1970) is one way to accomplish this.

Those persons who accept Professor Banfield's thesis will undoubtedly be accused of propagating some sort of nihilism. This is to be expected since, as the professor points out, Americans as a group endorse the principle of "Don't just sit there. Do something."—**Reprinted from *Massachusetts Physician*, June 1971, with the kind permission of Carl Bearse, M.D., Editor.**

Editorial Notes . .

Dr. Antonio R. Gasset, chief resident and instructor in ophthalmology at the University of Florida at Gainesville, has received a national award for his work in devising a soft hydrophilic contact lens. The lens is especially useful in providing protection for corneal irregularities, cases of bullous keratopathy, the drying sydromes and corneal ulcers. They are so nontraumatic they can be worn constantly and can be impregnated with medicine which is distributed to the cornea over a long time.

The University of North Carolina has been working with a live vaccine against Mycoplasma pneumoniae. According to the National Society for Medical Research they have demonstrated that protec-

tion can be conferred on laboratory animals. At least half of all pneumonia occurring in adolescence and young adulthood is caused by this organism.

The Pharmaceutical Manufacturers Association opposes the move of the American Pharmaceutical Association to repeal laws against substitution in prescription filling. The PMA president, C. Joseph Stetler, describes the fundamental flaw in the A.Ph.A. effort as "a failure to recognize the mounting evidence about the lack of equivalency of products with the same generic name."

At least 50% of the blood for transfusion is obtained from paid donors. There is a difference between donated blood and purchased blood, aside from the cost in dollars. As the amount of purchased blood increases it comes more and more from poor people and, as a result, the risk of transmitting hepatitis may be increasing also. The Health Insurance Institute strongly advises that relatives and close friends donate blood and make it possible for blood banks to remain solvent while purchasing little or no blood.

Modern drug rehabilitation programs are emphasizing the tendency of narcotic addicts to be cunningly resourceful and to cheat in order to remain in the program. Dr. C. G. DeAngelis, of Pfizer Pharmaceuticals, recently told the International Council on Alcohol and Addiction that physicians should be cautious about interpreting diagnostic test results. Either "false negatives" or "false positives" can damage the treatment. Since the addict started taking drugs because of emotional or behavioral troubles the physician must consider the mental side of the problem as much as the tests which are intended to indicate the presence or absence of drugs in his system.

A new pollution hazard has been identified. A research team at the University of Cincinnati finds that tobacco smoke contains cadmium. The smoke that drifts from the burning end of cigarets, cigars and pipes contains most of the cadmium, lesser amounts are in the inhaled smoke. Large doses can cause acute poisoning in man. Lower doses are implicated in hypertension, bronchitis and emphysema. Unlike chromium, copper and zinc, cadmium is not an essential element for man.

A polystyrene resin has been discovered which, when mixed in proper proportion with a mouse's food, enables the mouse to excrete mercury, which has been injected into his body, twice as fast as would occur normally. The test animals were found to have a brain mercury-level five times less than the control mice. The National Society for Medical Research reports that the resin has had no human testing, but it will be considered for ridding the body of abnormal amounts of mercury and will also be investigated as a means of reducing the absorption rate of mercury from foods which have been ingested. It is estimated that, in 1968, 4.77 million pounds of mercury were released into the atmosphere, mostly because of the burning of fossil fuels.

Pollution is widespread because the processes which pollute are also the cheapest method of doing the job. Doing away with pollution is going to be expensive. The VA is redoing the boiler plant at the Brecksville, Ohio, VA hospital to bring it within the pollution requirements of the Cleveland area. The estimated cost of changing from coal to gas and oil is in excess of $600,000.

The amount of RhoGAM which is used would indicate that only about one-half of the women who need protection against Rh sensitization are receiving it. Each Rh negative woman should receive the vaccine when she delivers an Rh positive child. In addition to this, the vaccine should be used with all abortions which occur in Rh negative women because the Rh status of the fetus cannot be determined. Rh negative women who accidentally receive Rh positive blood as transfusion also need the RhoGAM protection.

The Veterans Administration is computerizing its card index system and other records. Of the 96 million veteran records, 56 million will be converted this year and 40 million will be computerized in 1973. The VA is also adopting computers for fiscal accounting procedures, veteran loan records, supply records in hospitals, and for record handling in laboratories.

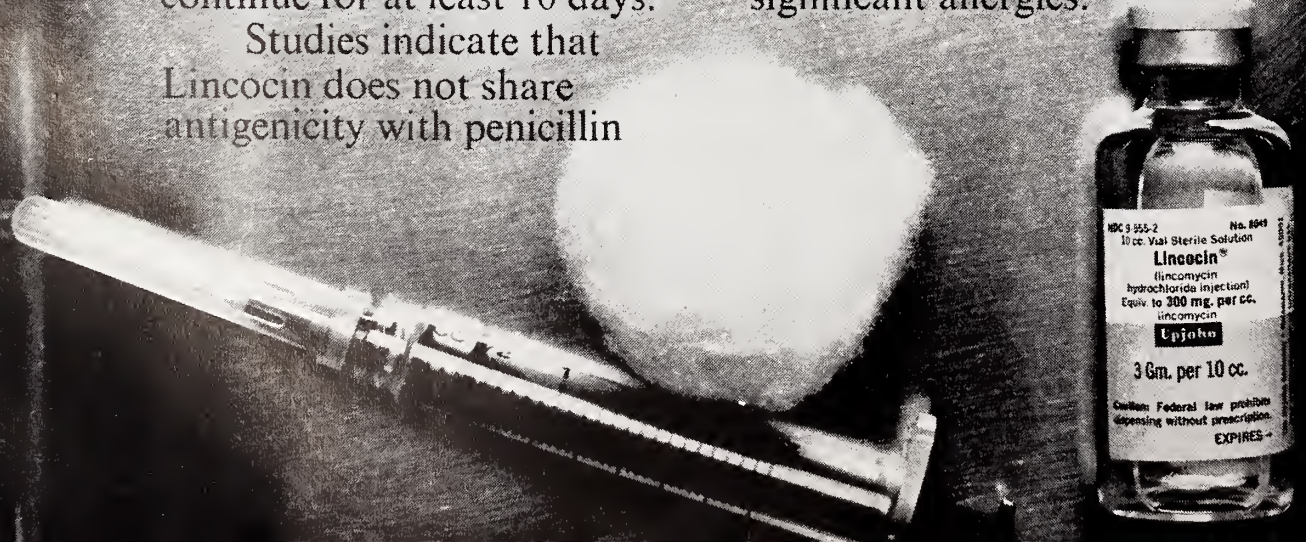
Research into the mechanisms of learning to read is conducted at the University of California, at least in part, by training a chimpanzee to recognize word and sentence symbols. The symbols are plastic objects of varying shapes, sizes, textures and colors. The chimp now has attained a "vocabulary" of 120 words and can understand an eight-word sentence. The animal is challenged by displaying the plastic symbols in proper order. The answer is indicated by the chimp's use of the symbols or by the appropriate behavior. A younger chimp is now being trained in an effort to make communication possible between two dumb animals. If this is successful, the trained chimps will be assessed for their ability to teach the "language" to an untrained chimp. ◄

Hypersensitivity to penicillin is a good reason to consider Lincocin®

(lincomycin hydrochloride)

Lincocin (lincomycin hydrochloride, Upjohn) has produced a high percentage of satisfactory responses in patients with mild, moderate and severe infections due to susceptible streptococci, pneumococci and staphylococci (including many penicillinase-producing strains). With β-hemolytic streptococcal infections, treatment should continue for at least 10 days.

Studies indicate that Lincocin does not share antigenicity with penicillin compounds. However, hypersensitivity reactions such as angioneurotic edema, serum sickness and anaphylaxis have been reported, some of these in patients known to be sensitive to penicillin. As with any antibiotic, Lincocin (lincomycin hydrochloride, Upjohn) should be used cautiously in patients with histories of asthma or other significant allergies.



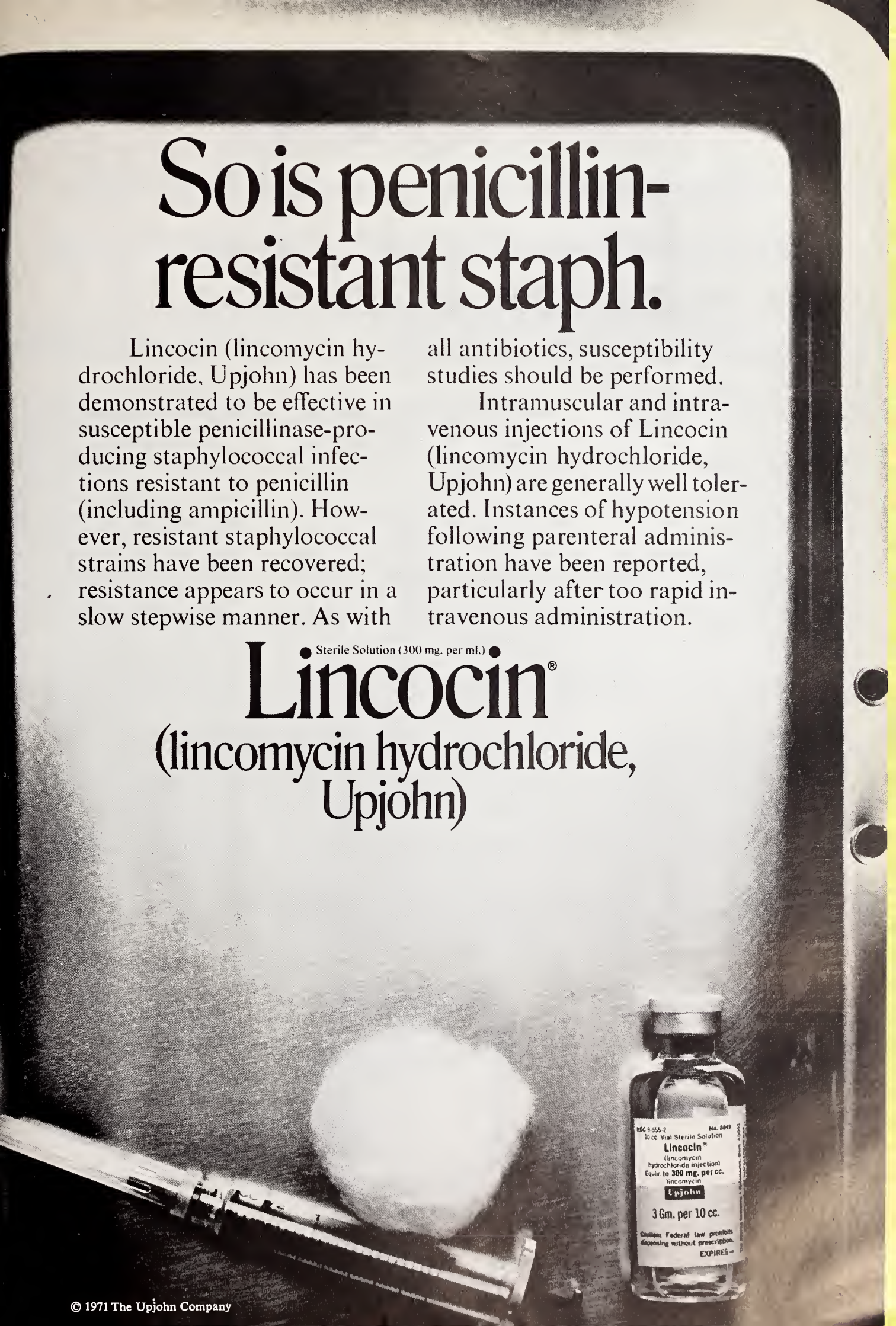
So is penicillin-resistant staph.

Lincocin (lincomycin hydrochloride, Upjohn) has been demonstrated to be effective in susceptible penicillinase-producing staphylococcal infections resistant to penicillin (including ampicillin). However, resistant staphylococcal strains have been recovered; resistance appears to occur in a slow stepwise manner. As with all antibiotics, susceptibility studies should be performed.

Intramuscular and intravenous injections of Lincocin (lincomycin hydrochloride, Upjohn) are generally well tolerated. Instances of hypotension following parenteral administration have been reported, particularly after too rapid intravenous administration.

Sterile Solution (300 mg. per ml.)

Lincocin®
(lincomycin hydrochloride, Upjohn)



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Sterile Solution (300 mg. per ml.)

Lincocin®

(lincomycin hydrochloride, Upjohn) for respiratory tract, skin, soft-tissue, and bone infections due to susceptible streptococci, pneumococci, and staphylococci

Each preparation contains:	Lincomycin hydrochloride monohydrate equivalent to lincomycin base
250 mg. Pediatric Capsule	250 mg.
500 mg. Capsule	500 mg.
*Sterile Solution per 1 ml.	300 mg.
Syrup per 5 ml.	250 mg.

*Contains also: Benzyl Alcohol 9 mg.; and, Water for Injection—q.s.

An antibiotic chemically distinct from others available, indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed.

CONTRAINDICATIONS: History of prior hypersensitivity to Lincocin (lincomycin hydrochloride). Not indicated in the treatment of viral or minor bacterial infections.

WARNINGS: Cases of severe and persistent diarrhea have been reported and at times drug discontinuance has been necessary. This diarrhea has been occasionally associated with blood and mucus and at times has resulted in acute colitis. This reaction usually has been associated with oral therapy, but occasionally has been reported following parenteral therapy. Although cross sensitivity to other antibiotics has not been demonstrated, make careful inquiry concerning previous allergies or sensitivities to drugs. Safety for use in pregnancy has not been established and Lincocin is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

PRECAUTIONS: Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of β-hemolytic streptococci infection for ten days to diminish likelihood of rheumatic fever or glomerulonephritis.

ADVERSE REACTIONS: *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatment. *Skin and mucous membranes*—Skin rashes, urticaria, vaginitis, and rare instances of exfoliative and vesiculobullous dermatitis have been reported. *Liver*—Although no direct relationship to liver dysfunction is established, jaundice and abnormal liver function tests (particularly serum transaminase) have been observed in a few instances.

Cardiovascular—Instances of hypotension following parenteral administration have been reported, particularly after too rapid I.V. administration. Rare instances of cardiopulmonary arrest have been reported after too rapid I.V. administration. If 4.0 grams or more administered I.V., dilute in 500 ml. of fluid and administer no faster than 100 ml. per hour. *Local reactions*—Excellent local tolerance demonstrated to intramuscularly administered Lincocin. Reports of pain following injection have been infrequent. Intravenous administration of Lincocin in 250 to 500 ml. of 5% glucose in distilled water or normal saline has produced no local irritation or phlebitis.

HOW SUPPLIED: *250 mg. and 500 mg.* Capsules—bottles of 24 and 100.

Sterile Solution, 300 mg. per ml.—2 and 10 ml. vials and 2 ml. syringe.

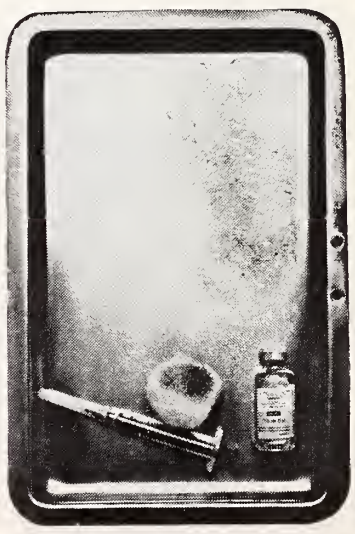
Syrup, 250 mg. per 5 ml.—60 ml. and pint bottles.

For additional product information, consult the package insert or see your Upjohn representative.

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The Upjohn Company
Kalamazoo
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122nd
Annual Convention

INDIANA STATE MEDICAL ASSOCIATION

October 12, 13 and 14, 1971

All Events on Eastern Standard Time

Murat Temple

Indianapolis, Indiana

Complete Program and Annual Reports on Following Pages

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Official Call to the House of Delegates

The next annual session of the Indiana State Medical Association will be held at the Murat Temple, Indianapolis, Indiana, October 12, 13 and 14, 1971.

The House of Delegates will be constituted as follows: Marion County, twenty-one delegates; Lake County, nine delegates; Allen County, six delegates; St. Joseph and Vanderburgh county societies, each five delegates; Delaware-Blackford, Owen-Monroe and Tippecanoe county societies, each three delegates; Bartholomew-Brown, Daviess-Martin, Dearborn-Ohio, Elkhart, Fayette-Franklin, Fountain-Warren, Harrison-Crawford, Jackson-Jennings, Jefferson-Switzerland, LaPorte, Madison, Parke-Vermillion, Vigo and Wayne-Union county societies, each two delegates; the other fifty-seven county societies, each one delegate; fourteen trustees and the ex-presidents, namely, Herman M. Baker, Karl R. Ruddell, M. A. Austin, Wm. Harry Howard, M. C. Topping, Kenneth L. Olson, Earl W. Mericle, Guy A. Owsley, Maurice E. Gloek, Donald E. Wood, Joseph M. Black, Kenneth O. Neumann, Eugene S. Rifner, Patriek J. V. Corcoran and Lowell H. Steen, and ex-officio, the president, president-elect, the executive secretary, the treasurer and assistant treasurer of this Association, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the President or person presiding shall cast the deciding vote. Two delegates are to be selected by the Indiana Chapter Student American Medical Association who shall be seated though without power to vote.

All delegates have been certified by their county medical societies. No delegate will be seated unless wearing the official badge.

The House of Delegates will convene promptly at 9:00 a.m. Tuesday, October 12, 1971, in the Shrine Club and again at 2:00 p.m., EST, Thursday, October 14, 1971, in the Shrine Club.

The order of business will be as follows:

1. Call to order by the president.
2. Invocation.
3. Roll eall and seating of qualified delegates.
4. Announeements from the chair.
5. Tribute to members of the House or those who served the association in an official capacity and who have died since the 1970 session.
6. Reading of the minutes of previous meetings.
7. Introduetion of guests.
8. President's Address.
9. Appointment of Referenee Committees and assignment of meeting rooms.
10. Unfinished business.
11. Address of president-eleet.
12. Report of president of the Woman's Auxiliary.
13. Report of Indiana Chapter Student AMA.
14. Report of president of Blue Shield.
15. Report of executive secretary.
16. Report of treasurer.
17. Report of chairman of the Board.
18. Reports of trustees.
19. Report of Journal *editor*.
20. Report of AMA delegates.
21. Report of State Board of Medical Registration and Examination.
22. Reports of committees and commissions.

COMMITTEES:

(1) Exeeutive
(2) Grievance
(3) Student Loan
(4) Medical-Legal Review
(5) Future Planning
(6) Sports and Medicine
(7) Medicine and Religion

COMMISSIONS:

(1) Convention Arrangements
(2) Constitution and Bylaws
(3) Legislation
(4) Public Information
(5) Governmental Medical Serviees
(6) Public Health
(7) Voluntary Health Agencies
(8) Inter-Professional Relations
(9) Medical Eeonomics and Insuranee
(10) Medical Education and Lieensure
(11) Speeial Activities
(12) Aging
(13) Emergency Medical Services
(14) Specialty Medicine

23. New Business:
    (1) Matters referred by the Board of Trustees
    (2) Matters referred by the Executive Committee
    (3) Resolutions
    (4) Selection of city for 1975 meeting.
        1972 — Indianapolis — October 9 - 12
        1973 — Indianapolis — October 16 - 18
        1974 — Indianapolis — Oetober 14 - 18

The Board of Trustees recommends that the 1975 and 1976 meetings be held in Indianapolis.

The election of officers will be first order of business at the second meeting of the House of Delegates. In addition to the regular officers, the terms of the following AMA delegates and alternates expire December 31, 1971, and their successors must be elected at the session: delegates to the Ameriean Medical Association to succeed Jack E. Shields, Brownstown and John S. Farquhar, Jr., Fort Wayne; alternate delegates to succeed Patrick J. V. Corcoran, Evansville, and Thomas C. Tyrrell, Hammond.

Delegates from the First, Fourth, Seventh, Tenth and Thirteenth Districts are reminded that the terms of their trustees will expire October 14, 1971, and new trustees should be elected to succeed the following:

First — Gilbert M. Wilhelmus, Evansville
Fourth — Robert M. Reid, Columbus
Seventh — James H. Gosman, Indianapolis
Tenth — Vincent J. Santare, Munster
Thirteenth — Otis R. Bowen, Bremen

Some of these elections already may have been held, but they should be reported to the House of Delegates at this session for confirmation.

JAMES A. WAGGENER, Exeeutive Secretary

HOUSE OF DELEGATES

Indiana State Medical Association

Indianapolis—October 12, 13 and 14, 1971

County and Delegates	Alternates
ADAMS (1)	
Norman E. Beaver, Berne	John E. Doan Decatur
ALLEN (6)	
Jerald L. Andrew, Fort Wayne	William E. Brandt, Fort Wayne
Fred W. Dahling, Fort Wayne	William R. Cast, Fort Wayne
John S. Farquhar, Jr., Fort Wayne	William R. Clark, Jr., Fort Wayne
DeWayne L. Hull, Fort Wayne	Richard W. Emme, Fort Wayne
Marvin E. Priddy, Fort Wayne	Ronald G. Kleopfer, Fort Wayne
Jeff H. Towles, Fort Wayne	Edwin E. Morey, Fort Wayne
BARTHOLOMEW-BROWN (2)	
Kenneth D. Schneider, Columbus	
Robert Seibel, Nashville	
BENTON (1)	
D. L. McKinney, Otterbein	Thomas J. Stolz, West Lafayette
BOONE (1)	
Don W. Boyer, Lebanon	
CARROLL (1)	
T. Neal Petry, Delphi	Alvan L. Eller, Flora
CASS (1)	
Eugene T. Karnafel, Logansport	Richard L. Glendening, Logansport
CLARK (1)	
David H. Jones, Charlestown	William R. Witt Jeffersonville
CLAY (1)	
Charles Moon, Brazil	Everett Conrad, Brazil
CLINTON (1)	
Robert A. Hedgcock, Frankfort	Charles K. Bush, Kirklin
DAVIESS-MARTIN (2)	
Robert H. Rang, Washington	Marshall H. Seat, Washington
Robert E. Chattin, Loogootee	E. B. Lett, Loogootee
DEARBORN-OHIO (2)	
Leslie M. Baker, Aurora	Henry Conrad, Lawrenceburg
Gordon S. Fessler, Rising Sun	Delfin David, Rising Sun
DECATUR (1)	
Robert Acher, Greensburg	
DeKALB (1)	
J. Robert Edwards Auburn	John Harvey, Auburn
DELAWARE-BLACKFORD (3)	
Donald R. Taylor, Muncie	Warren L. Bergwall, Muncie
Ross Egger, Daleville	Joseph I. Pippinger, Muncie
Paul E. Burns, Montpelier	Severino T. Sulit, Hartford City
DUBOIS (1)	
Edward J. Ploetner Jasper	M. Donald Bomalaski, Jasper
ELKHART (2)	
Thomas A. Elliott, Elkhart	Patrick Campbell, Elkhart
James D. Finfrock, Elkhart	Frederick W. Bigler, Goshen
FAYETTE-FRANKLIN (2)	
William F. Kerrigan, Connersville	George M. Ellis, Connersville
Perry Seal, Brookville	Noli Guinigundo, M.D. Brookville
FLOYD (1)	
Marshall H. Buchman, New Albany	
FOUNTAIN-WARREN (2)	
Max Hoffman, Covington	Lowell Stephens, Covington
S. Salvo Williamsport	Carl A. Nelson, West Lebanon
FULTON (1)	
Dean K. Stinson, Rochester	J. D. Richardson, Rochester
GIBSON (1)	
J. F. Peck, Princeton	W. R. Wells, Princeton
GRANT (1)	
Robert M. Brown, Marion	Barton T. Smith, Marion
GREENE (1)	
Sam I. Rotman Jasonville	M. S. Mount, Bloomfield
HAMILTON (1)	
A. Adrian Lanning, Noblesville	Joe R. Lloyd, Noblesville

County and Delegates	Alternates
HANCOCK (1)	
James T. Anderson, Greenfield	J. L. Garrison, Cumberland
HARRISON-CRAWFORD (2)	
Samuel W. Martin, Corydon	
L. H. Blessinger, Corydon	
HENDRICKS (1)	
Eric D. Clark, Plainfield	
HENRY (1)	
David R. Cain, New Castle	William S. Robertson, New Castle
HOWARD (1)	
Warren McClure, Kokomo	
HUNTINGTON (1)	
Richard W. Wagner, Huntington	
JACKSON-JENNINGS (2)	
Harry Baxter, Seymour	Kenneth Bobb, Seymour
John C. Linson, Seymour	William A. Johnson, North Vernon
JASPER (1)	
Kenneth Ahler, Rensselaer	Robert W. Green, Rensselaer
JAY (1)	
James Fitzpatrick, Portland	William Cripe, Portland
JEFFERSON-SWITZERLAND (2)	
Ott B. McAtee, Madison	Robert Johnson, Madison
Howard C. Johnson, Madison	
JOHNSON (1)	
Joseph Young, Greenwood	Joseph F. Ferrara, Franklin
KNOX (1)	
Herbert O. Chattin, Vincennes	Daniel Combs, Vincennes
KOSCIUSKO (1)	
Wymond B. Wilson, Mentone	
LA GRANGE (1)	
M. O. Mellinger, La Grange	F. X. Colligan, Topeka
LAKE (9)	
Walfred A. Nelson, Gary	J. P. Birdzell, Crown Point
T. C. Tyrrell, Hammond	C. T. Disney, Gary
William G. Grosso, East Chicago	
Joseph Sala, Gary	Lee Trachtenberg, Munster
L. W. Neal, Munster	Donald H. Rudser, Whiting
Charles Egnatz, Schererville	Robert J. Goldstone, Gary
Theodore R. Espy, Gary	Charles Egnatz, Schererville
J. J. Reed, Hobart	Arthur Goldstone, Gary
D. T. Ramker, Hammond	

County and Delegates	Alternates
LA PORTE (2)	
Fred Carter, LaPorte	Barbara Backer, LaPorte
John Luce, Michigan City	Frank McGue, Michigan City
LAWRENCE (1)	
Florian S. Dino, Bedford	James L. Mount, Bedford
MADISON (2)	
T. S. Doles, Middletown	Robert D. Williams, Anderson
William R. Kopp, Anderson	John R. Wagoner, Anderson
MARION (21)	
James H. Gosman, Indianapolis	George A. Clark, Indianapolis
Dwight W. Schuster, Indianapolis	Joseph T. Farrell, Indianapolis
John O. Butler, Indianapolis	Edward R. Gabovitch, Indianapolis
Joseph C. Finneran, Indianapolis	John D. Graham, Indianapolis
I. E. Michael, Indianapolis	Rex M. Joseph, Indianapolis
John W. Beeler, Indianapolis	Gerald J. Kurlander, Indianapolis
Donald M. Schlegel, Indianapolis	Stafford W. Pile, Jr., Indianapolis
Morris E. Thomas, Indianapolis	Hubert N. Grimes, Indianapolis
Malcolm L. Wrege, Indianapolis	George Klutinoty, Indianapolis
Albert M. Donato, Indianapolis	George T. Lukemeyer, Indianapolis
A. Alan Fischer, Indianapolis	Robert N. McCallum, Indianapolis
Gordon C. Jones, Indianapolis	Dennis Nicholas, Indianapolis
Arvine G. Popplewell, Indianapolis	Michael L. Yacko, Indianapolis
Donald E. Stephens, Indianapolis	Robert J. Yingling, Indianapolis
Donald E. Wood, Indianapolis	Richard A. Brickley, Indianapolis
William A. Karsell, Indianapolis	Max E. Freeman, Carmel
Loren H. Martin, Indianapolis	M. Richard Harding, Indianapolis
Edwin S. McClain, Indianapolis	Henry G. Nester, Indianapolis
Charles E. Test, Indianapolis	John N. Pittman, Indianapolis
Hugh K. Thatcher, Jr., Indianapolis	Francis W. Price, Indianapolis
Hugh L. Williams, Indianapolis	Edward F. Steinmetz, Indianapolis
MARSHALL (1)	
James Robertson, Plymouth	
MIAMI (1)	
Lloyd Hill, Peru	
MONTGOMERY (1)	
Richard Eggers, Crawfordsville	James M. Kirtley, Crawfordsville
MORGAN (1)	
Kenneth E. Comer, Mooresville	Maurice A. Turner, Martinsville
NEWTON (1)	
M. F. Guzman, Morocco	B. E. Imperial, Kentland

County and Delegates	Alternates
NOBLE (1)	
Max Sneary, Avilla	J. A. Greenlee, Avilla
ORANGE (1)	
Phillip T. Hodgin, Orleans	C. X. McCalla, Paoli
OWEN-MONROE (3)	
Robert Rose, Spencer	M. S. Brown, Spencer
Thomas O. Middleton, Bloomington	William C. Link, Bloomington
Wm. Courtney Seagle, Bloomington	Jean A. Creek, Bloomington
PARKE-VERMILLION (2)	
J. Franklin Swaim, Rockville	C. Harstad, Rockville
John W. Somerville, Clinton	A. M. Montecillo, Clinton
PERRY (1)	
Fred Smith, Jr., Tell City	Gene E. Ress, Tell City
PIKE (1)	
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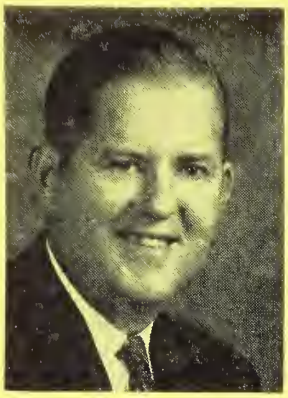
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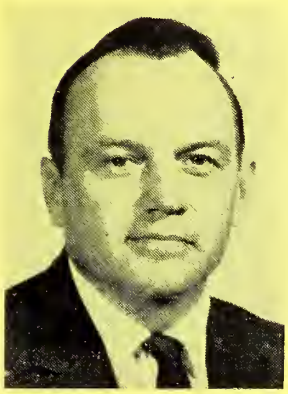
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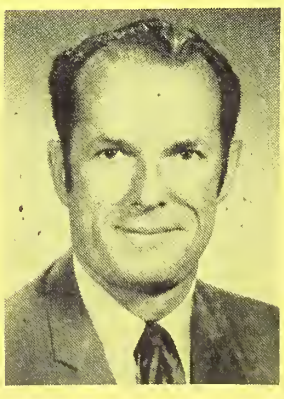
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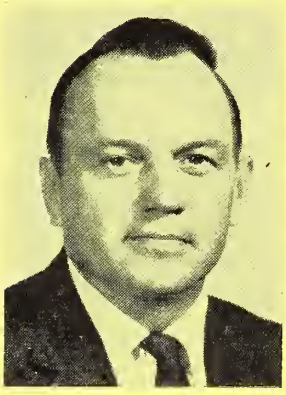
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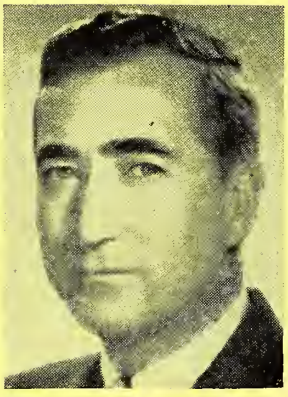
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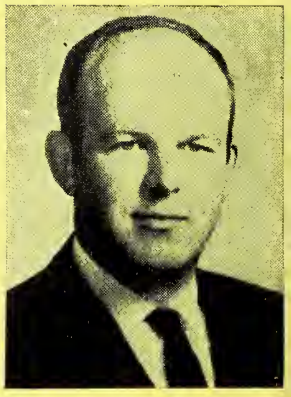
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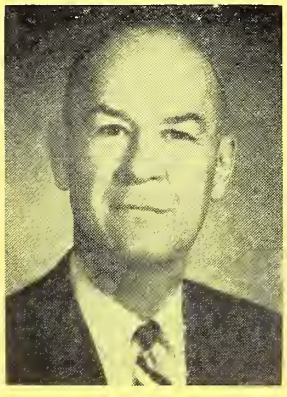
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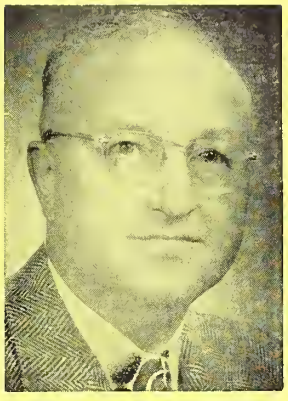
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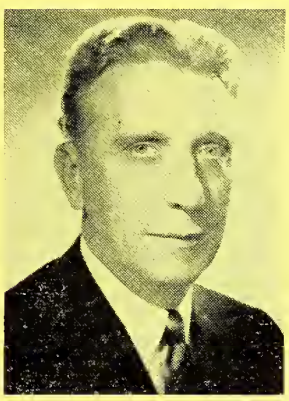
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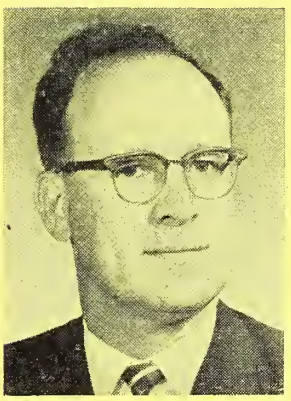
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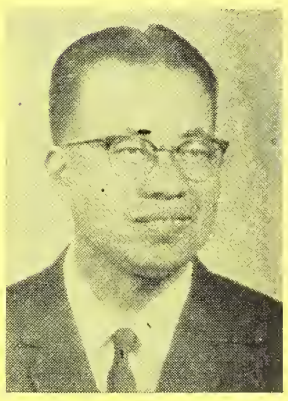
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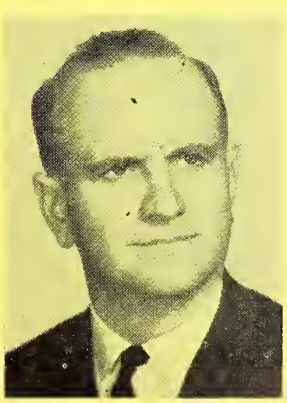
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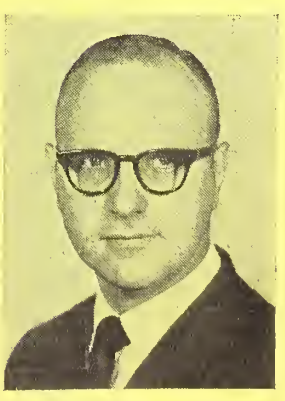
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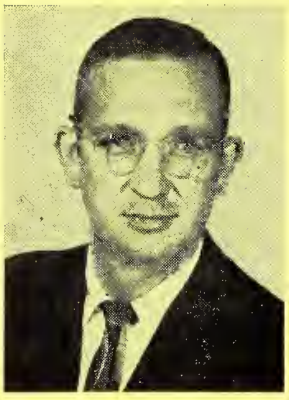
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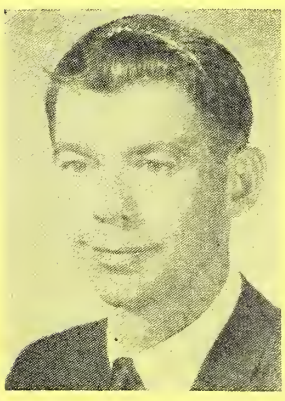


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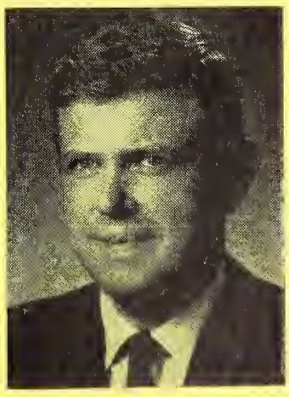


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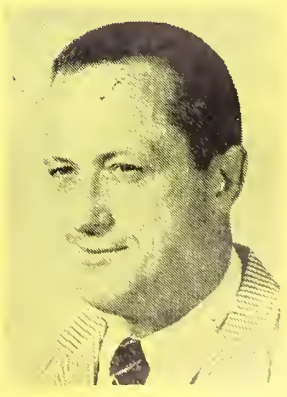
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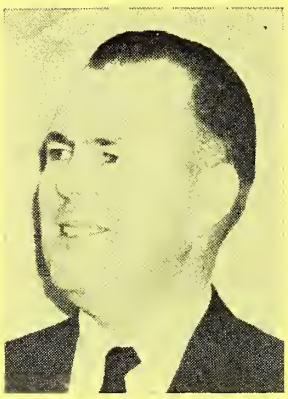


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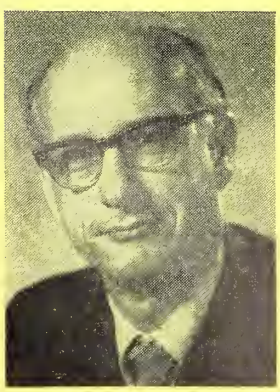


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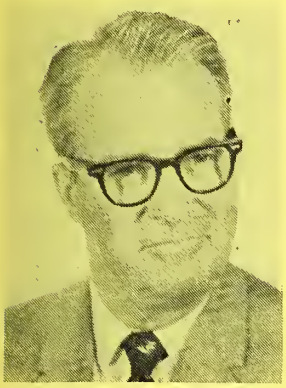
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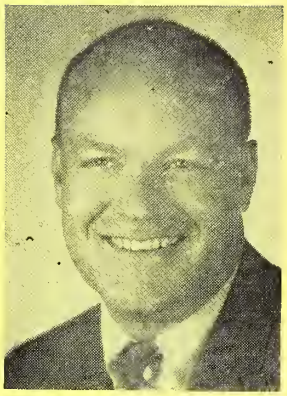
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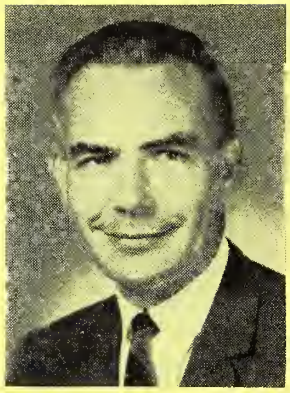
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Schedule of Events

122nd Annual Convention
Indiana State Medical Association
Murat Temple
Indianapolis, Indiana

(All Events on Eastern Standard Time)
(The scientific program for the 122nd annual convention of the Indiana State Medical Association is acceptable for 3½ prescribed and 4 elective hours by the American Academy of General Practice.)

Monday, October 11, 1971

9:00 a.m. Executive Committee meeting, Hilton Hotel

12:00 noon Executive Committee and Board of Trustees luncheon, Blue Cross-Blue Shield Building

2:00 p.m. Board of Trustees meeting, Hilton Hotel

Monday Evening, October 11, 1971

8:00 p.m. Annual Trustees dinner, Third Floor Dining Room, Columbia Club

Tuesday Morning, October 12, 1971

8:00 a.m. Board of Trustees breakfast meeting, Hilton Hotel

8:30 a.m. Registration begins, Theatre Lobby, Murat Temple

8:30 a.m. Opening of technical and scientific exhibits, Lounge Room, Murat Temple

9:00 a.m. Meeting of House of Delegates, Shrine Club

11:00 a.m. Editorial Board meeting, Room C, Shrine Club (lower level) (Luncheon 12 Noon)

11:00 a.m. Golf Tournament Hillcrest Country Club

12 noon IMPAC Luncheon, Egyptian Room, Murat Temple

Tuesday Afternoon, October 12, 1971

Time allowed to view technical and scientific exhibits, Lounge Room, Murat Temple

2:00 p.m. Reference Committee meetings, Shrine Club (lower level)

- Reference Committee No. 1. Room A, Shrine Club (lower level)
- Reference Committee No. 2. Room B, Shrine Club (lower level)
- Reference Committee No. 3. Room D, Shrine Club (lower level)
- Reference Committee No. 4. Room E, Shrine Club (lower level)
- Reference Committee No. 5. Room F, Shrine Club (lower level)

4:00 p.m. Time allowed to view technical and scientific exhibits, Lounge Room. Murat Temple

6:00 p.m. Women Physicians Dinner. La Tour Restaurant, Indiana Bank Tower

SPEAKERS



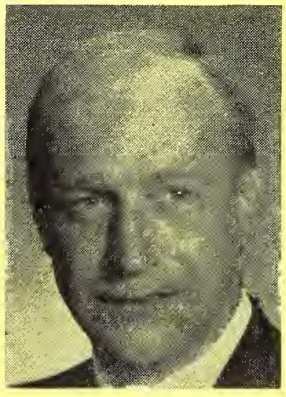
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Indianapolis

Director, Medical Communications Division, Lilly Research Laboratories; founder and editor, the American Journal of Clinical Nutrition (1951-61); diplomate, American Board of Internal Medicine; founder, American Society for Clinical Nutrition; Fellow, American College of Physicians; M.D. degree from New York University College of Medicine, 1943.



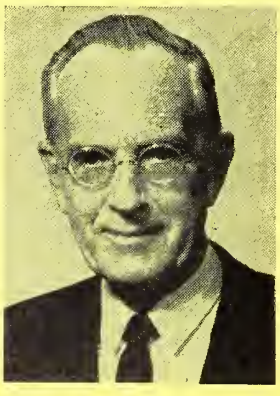
LANDRUM BOLLING
Richmond, Ind.

President of Earlham College since 1958; author and former foreign correspondent and teacher of political science; member of the Regional Advisory Committee of the Institute of International Education and of the board of directors of the National Council of Associations for International Studies; A.M. degree from University of Chicago, 1938.



JOHN I. NURNBERGER, M.D.
Indianapolis

Professor and Chairman, Department of Psychiatry, and Director, Institute of Psychiatric Research, I.U. Medical Center; president, Society of Biological Psychiatry; Research Fellow in Cytochemistry of Nervous System at the Medical Nobel Institute for Cell Research and Genetics, Stockholm, Sweden, 1949-50; M.D. degree from Northwestern University Medical School, 1943.



IRVINE H. PAGE, M.D.
Cleveland, Ohio

Editor, **Modern Medicine**; former director of Cleveland Clinic Foundation and of Lilly Laboratory for Clinical Research; chairman, Advisory Committee on Medical Science, AMA; Trustee and Honorary Fellow, American College of Cardiology; recipient of Albert Lasker Award (1958), Passano Foundation Award (1967), Sheen Award (1968), and Stouffer Prize (1970); past president of American Society for the Study of Arteriosclerosis and of American Heart Association; M.D. degree from Cornell Medical College, 1926.

Tuesday Evening, October 12, 1971

8:00 p.m. to 10:00 p.m. — Panel Discussion THE ACHIEVEMENT OF HAPPINESS, Ballroom, Indianapolis Hilton Hotel

Moderator: S. O. WAIFE, M.D., Indianapolis, Chairman, Commission on Convention Arrangements

Guest Speakers:

"How to be Happy in 1971, though a Father,"
DR. LANDRUM BOLLING, Richmond, President of Earlham College

"How to be Happy in 1971, though a Husband,"
JOHN I. NURNBERGER, M.D., Indianapolis, Chairman, Department of Psychiatry, Indiana University School of Medicine

"How to be Happy in 1971, though a Physician,"
IRVINE H. PAGE, M.D., Cleveland, Ohio, Editor, *Modern Medicine*

Wednesday Morning, October 13, 1971

8:00 a.m. — Board of Trustees breakfast meeting, Hilton Hotel

8:30 a.m. — Registration continues, Theatre Lobby, Murat Temple

8:30 a.m. — Opening of technical and scientific exhibits, Lounge Room, Murat Temple

10:00 a.m. to 4:00 p.m. — SCIENTIFIC MOTION PICTURE PROGRAM, Candidates Room, Murat Temple (upper level)

Partial List of Films to Be Shown

"Medical Potential of Lasers"
"Radioisotopes in the Diagnosis of Cancer"
"The Secretion of Insulin"
"Differential Diagnosis of Parkinson Diseases"
"Courtroom Confrontation"
"The Penetrating Eye"

Time allowed to view technical and scientific exhibits, Lounge Room, Murat Temple

12:00 Noon — ISMA Past Presidents Luncheon, Hilton Hotel, Room 928-32

SECTION PROGRAMS

12 Noon

SECTION ON SURGERY, joint luncheon meeting with Indiana Chapter, International College of Surgeons and Indiana Chapter, American College of Surgeons, Mecca Room, Shrine Club (lower level)

"Current Concepts in the Postgastrectomy Dumping Syndrome,"

JOHN E. JESSEPH, M.D., Indianapolis, Chairman, Department of Surgery, Indiana University School of Medicine

"Hyperalimentation,"

HAROLD G. HALBROOK, M.D., Methodist Hospital, Indianapolis

Election of Section Officers for 1972



JOHN ERVIN JESSEPH, M.D.
Indianapolis

Professor and Chairman, Department of Surgery, Indiana University School of Medicine; consultant, Veterans Administration Hospital, Indianapolis; M.D. degree from University of Washington, 1953.

9:00 a.m. to 12 Noon

JOINT MEETING OF THE SECTION ON INTERNAL MEDICINE, AMERICAN COLLEGE OF PHYSICIANS AND INDIANA SOCIETY OF INTERNAL MEDICINE, *Hilton Hotel Ballroom*

Kenneth G. Kohlstaedt, M.D., F.A.C.P., Vice President, American College of Physicians, Chairman



HAROLD HALBROOK, M.D.
Indianapolis

Chief Resident in general surgery, Methodist Hospital, Indianapolis; M.D. degree from Indiana University School of Medicine, 1965.

9:00 to 10:00 a.m.

"Psychiatric Interview for the Internist,"

EPHRAIM T. LISANSKY, M.D., M.A.C.P., Baltimore, Maryland



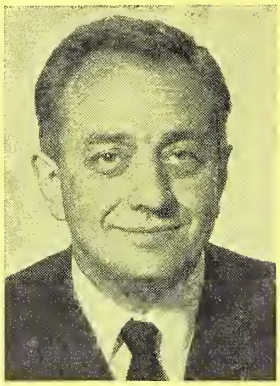
EPHRAIM T. LISANSKY, M.D.
Baltimore, Md.

Associate Professor of Medicine and Psychiatry, University of Maryland School of Medicine; lecturer, U. of Maryland Dental School, School of Social Work and School of Law; specialist in internal medicine and psychosomatic medicine; M.A.C.P., 1970; M.D. degree from University of Maryland, 1937.

10:00 to 10:15 a.m.

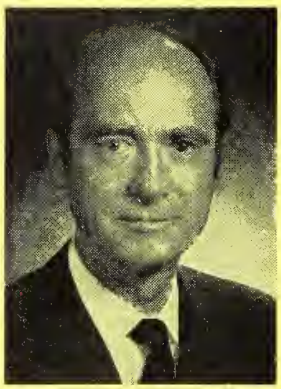
Intermission

SPEAKERS



ROBERT A. GOOD, M.D.
Minneapolis, Minn.

Professor and Head, Department of Pathology, University of Minnesota Medical School; member, World Health Organization Expert Advisory Panel on Immunology, WHO Experimental Ani-



HUGH R. BUTT, M.D.
Rochester, Minn.

Professor, University of Minnesota, Mayo Foundation, Mayo Graduate School of Medicine; consultant, Mayo Clinic, Mayo Foundation; specialist in internal medicine and gastroenterology; Fellow, Royal College of Physicians, London; M.D. degree from University of Virginia, 1933.



EDWIN C. EVANS, M.D.
Atlanta Ga.

Clinical Assistant Professor of Medicine, Emory University School of Medicine; diplomate of American Board of Internal Medicine; F.A.C.P.; president-elect, American Society of Internal Medicine; M.D. degree, Johns Hopkins School of Medicine, 1940.



EDWARD C. FRANKLIN, M.D.
New York City

Professor of Medicine, New York University College of Medicine; chairman, Rheumatic Diseases Study Group, N.Y.U. Medical Center; specialist in internal medicine; member, Society for Clinical Investigation, Society of Experimental Biology and Medicine; M.D. degree from N.Y.U. College of Medicine, 1950.



WALTER J. DALY, M.D.
Indianapolis

Professor and Chairman, Department of Medicine, Indiana University School of Medicine; specialist in internal medicine, pulmonary disease; M.D. degree from Indiana University School of Medicine, 1955.

10:15 to 11:45 a.m. — *"ABC's of Immunology,"* ROBERT A. GOOD, M.D., Minneapolis, Minnesota

12:45 to 1:00 p.m. — Business Meeting, Indiana Society of Internal Medicine — Joel Salon, M.D., F.A.C.P., President

1:00 to 1:20 p.m. — HUGH R. BUTT, M.D., F.A.C.P., Rochester, Minn., President, American College of Physicians

1:25 to 1:50 p.m. — EDWIN C. EVANS, M.D., F.A.C.P., Atlanta, President-elect, American Society of Internal Medicine

Wednesday Afternoon, October 13, 1971

Jas. O. Ritchey, M.D., M.A.C.P., Indianapolis
Glenn W. Irwin, Jr., M.D., F.A.C.P., Indianapolis, Dean, Indiana University School of Medicine,
Chairmen

2:00 to 3:15 p.m. — *"Immunological Applications in Clinical Medicine,"* EDWARD C. FRANKLIN, M.D., New York City

3:20 to 4:15 p.m. — Panel Discussion — Questions
WALTER DALY, M.D., Indianapolis, Moderator

ROBERT A. GOOD, M.D., Minneapolis
EDWARD C. FRANKLIN, M.D., New York
EPHRAIM T. LISANSKY, M.D., Baltimore

5:30 to 7:00 p.m. — PRESIDENT'S RECEPTION, Ballroom, Hilton Hotel

7:00 p.m. — Dinner — Hilton Hotel—(Sponsored by Section on Internal Medicine, ACP and ISIM)
Entertainment — Belles of Indiana
EVERYONE INVITED

10:00 a.m. SECTION ON GENERAL PRACTICE, Red Fez, Shrine Club (lower level)

"Progress Report, Department of Family Practice, Indiana University School of Medicine,"

A. ALAN FISCHER, M.D., Indianapolis, Department of Family Practice, Indiana University School of Medicine

10:30 a.m. *"Continuing Education,"*

ROSS EGGER, M.D., Daleville

11:00 a.m. *"The Patient Periodic Health Examination — Its Place in Practice,"*

EDWARD J. KOWALEWSKI, M.D., Akron, Penn.

Question-and-Answer Period

12 Noon JOINT LUNCHEON WITH SECTION ON PREVENTIVE MEDICINE AND PUBLIC HEALTH, Red Fez, Shrine Club (lower level)

"New Concepts of Personal and Environmental Health Services,"

JOHN J. HANLON, M.D., Rockville, Maryland, Assistant Surgeon General, Public Health Service

1:30 p.m. *"What the Computer Can Do for You,"*

FRED V. LIGHT, M.D., Cleveland, Ohio

Question-and-Answer Period

Election of Section Officers for 1972

SPEAKERS



A. ALAN FISCHER, M.D.
Indianapolis

Associate Professor and Director, Family Practice Program, Indiana University School of Medicine; member of AAGP Executive Committee, and Chairman, AAGP Commission on Education; diplomate, American Board of Family Practice; M.D. degree from Indiana University School of Medicine, 1952.



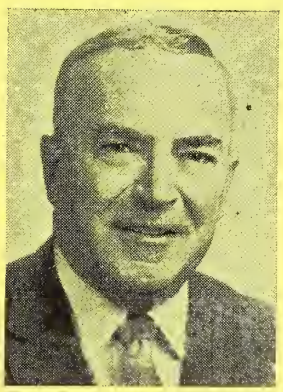
ROSS L. EGGER, M.D.
Daleville

Director of Family Practice Residency, Ball Memorial Hospital, Muncie; diplomate of the American Board of Family Practice; regional adviser, Education Commission of the AAGP; member, Advisory Committee for Continuing Medical Education and Physician Recognition Award Committee, AMA; M.D. degree from Indiana University School of Medicine, 1962.



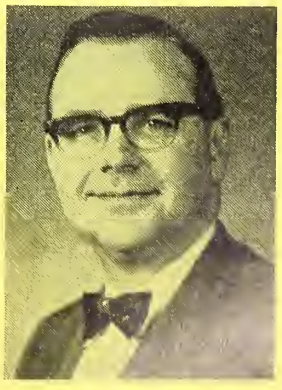
EDWARD J. KOWALEWSKI, M.D.
Akron Pa.

General practitioner; former chairman, Executive Committee, AAGP; member, Family Health Care Services Committee, USPHS; member, Expert Review Panel, DHEW; Voice of Medicine Award, 1968; M.D. degree from George Washington University Medical School.



JOHN J. HANLON, M.D.
Rockville, Md.

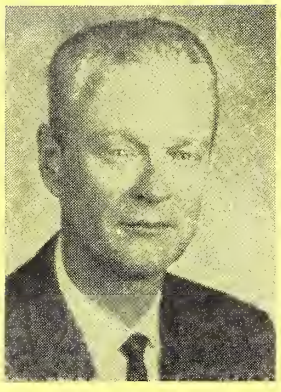
Assistant Surgeon General, U. S. Public Health Service; deputy administrator for Environmental Health Service, DHEW; consultant, World Health Organization; former professor and chairman, Department of Preventive Medicine and Public Health, Temple University School of Medicine; former president, American Public Health Association; M.D. degree from Wayne University, 1941.



FRED V. LIGHT, M.D.
Cleveland, Ohio

Past President of Ohio Academy of General Practice; member of AAGP committee on medical technology development; diplomate, American Board of Family Practice; M.D. degree from University of Arkansas School of Medicine, 1948.

SPEAKERS



WALTER HAINES SMARTT, M.D.
Los Angeles, Calif.

Chief, Division of Venereal Disease Control, Los Angeles County Health Department; assistant clinical professor of Community Medicine and Public Health, Unversity of Southern California; associate professor, Health and Safety Department, Health Education, California State College; M.D. degree from University of Virginia, 1948.



EUGENE C. KLATTE
Indianpolis

Chairman of the Department of Radiology, Indiana University Medical Center; diplomate, American Board of Radiology (Guest Examiner, 1964-68); M.D. degree from Indiana University School of Medicine, 1952.

12 Noon — SECTION ON PUBLIC HEALTH AND PREVENTIVE MEDICINE, joint luncheon meeting with SECTION ON GENERAL PRACTICE, Red Fez, Shrine Club (lower level)

"New Concepts of Personal and Environmental Health Services,"
JOHN J. HANLON, M.D., Rockville, Assistant Surgeon General, Public Health Service

1:45 p.m. — Section on Public Health and Preventive Medicine meeting to be held in Room F, Shrine Club (lower level)
Business Meeting, Henry G. Nester, M.D., Indianapolis, Presiding
Election of Section Officers for 1972

2:00 p.m. — *"New Developments in the Treatment and Control of Venereal Disease,"*
WALTER H. SMARTT, M.D., Chief, Venereal Disease Control Division, Los Angeles County Health Department, Los Angeles, Calif.

12 Noon — SECTION ON RADIOLOGY, joint luncheon meeting of the Section on Radiology and Indiana Roentgen Society, Inc., Room D, Shrine Club (lower level)

"Projected Radiology Programs at Indiana University School of Medicine"
EUGENE C. KLATTE, M.D., Chairman, Department of Radiology, Indiana University School of Medicine

2:00 p.m. — Tour of the new Radiology Department, Indiana University School of Medicine

12 noon — SECTION ON ANESTHESIOLOGY luncheon meeting, Card Room, Shrine Club (lower level)

"Management of Intractable Pain"
JAMES C. APPLETON, M.D.,
Dayton, Ohio
Election of Section Officers for 1972

12 noon

SECTION ON NERVOUS and MENTAL DISEASES, joint luncheon with Indiana Neurological Association, Northern Branch of the Indiana Psychiatric Society and the Indiana Psychiatric Society, Room E, Shrine Club (lower level)

"Epilepsy — Better Control with the Use of Serum Anticonvulsant Levels,"

JOSEPH B. GREEN, M.D., Indianapolis, Director Epilepsy Clinic, Indiana University Medical Center, and

ELIZABETH B. SOLOW, M.S., Indianapolis, Division of Neurosurgery, Indiana University Medical Center

Panel on EPILEPSY — PROBLEMS OF DAILY LIVING

Moderator—RAYMOND DEMBINSKI, Ed.D., Indianapolis, Administrator, Developmental Disabilities Program, Department of Neurology, Indiana University Medical Center

JOSEPH B. GREEN, M.D., Indianapolis, Director, Epilepsy Clinic, Indiana University Medical Center

ANTHONY G. BANET, Ph.D., Indianapolis, Director, Psychological Services, Community Mental Health Center, Marion County General Hospital

LAWRENCE C. HARTLAGE, Ph.D., Indianapolis, Department of Neurology, Indiana University Medical Center

SARAH McCLURE, A.C.S.W. (Social Worker) Indianapolis, Department of Neurology, Indiana University Medical Center

Election of Section Officers for 1972

SPEAKERS



JOSEPH B. GREEN, M.D.
Indianapolis

Professor of Neurology, Indiana University School of Medicine; Fellow, American Academy of Neurology; member, American Neurological Association; director, Developmental Disabilities Project and Epilepsy Clinic and EEG Laboratories, I.U. Medical Center; M.D. degree, Jefferson Medical College of Philadelphia, 1954.



ELIZABETH BUCHANAN SOLOW
Indianapolis

Assistant Professor, Division of Neurological Surgery, Indiana University School of Medicine; specialist in clinical biochemistry; M.S. degree from Indiana University, 1962.



ANTHONY G. BANET, JR., Ph.D.
Indianapolis

Director, Psychological Services, Community Mental Health Center, Marion County General Hospital; assistant professor of psychiatry, Indiana University School of Medicine; editor, **Indiana Psychologist**; consultant, Riley Hospital Epilepsy Clinic; Ph.D. degree from The Catholic University of America, 1965.



LAWRENCE C. HARTLAGE, Ph.D.
Indianapolis

Assistant Professor, Department of Neurology, Indiana University Medical Center; president-elect, National Rehabilitation Training Institute; consulting editor, Psychological Aspects of Disability and The School Psychologist; consultant, Indianapolis Goodwill Industries; Ph.D. degree from University of Louisville, 1967.

SPEAKERS



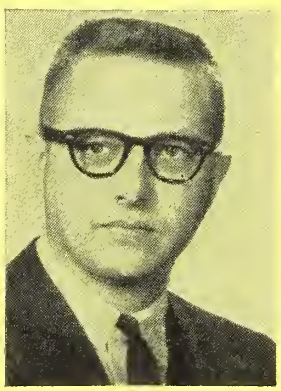
VICTOR H. MULLER, M.D.
Indianapolis

Medical Director, Community Blood Bank of Marion County, Inc.; specialist in pathology; M.D. degree from Indiana University School of Medicine, 1951.



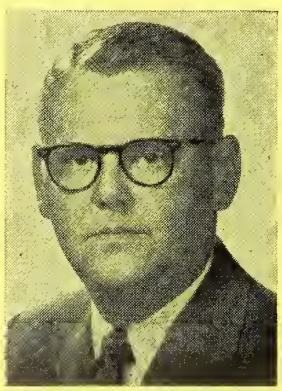
CARLETON D. NORDSCHOW, M.D.
Indianapolis

Chairman and Professor, Department of Clinical Pathology, Indiana University School of Medicine; consultant, Veterans Administration Hospital, Larue Carter Hospital; M.D. degree from University of Iowa, 1953.



PATRICK C. LOGAN, M.D.
Indianapolis

Indiana University Medical Center, Community Hospital; diplomate of American Board of Dermatologists; M.D. degree from Indiana University School of Medicine, 1964.



STEPHEN R. PHELPS M.D.
South Bend, Ind.

Consultant, St. Joseph's Hospital, South Bend; specialist in dermatology; M.D. degree from University of Kansas Medical School, 1946.

10:00 a.m. SECTION ON PATHOLOGY and FORENSIC MEDICINE, Room A, Shrine Club (lower level)
Moderator: DAVID L. ADLER, M.D., Columbus

"Use of Office Computer in the Laboratory,"
ROBERT L. COSTIN, M.D., Indianapolis

10:45 a.m. *"Competitive Protein Binding Assays,"*
JAMES R. MACKENZIE, M.D., Indianapolis

12 noon Luncheon. Business Meeting.
Election of Section Officers for 1972

1:00 p.m. *"The Testing for Hepatitis Associated Antigen — Implications and Complications"*
VICTOR H. MULLER, M.D., Indianapolis

1:45 p.m. *"Possible Lipid Differential Determination as a Monitor for Pulmonary Maturation,"*
CARLETON D. NORDSCHOW, M.D., Ph.D., Indianapolis

2:30 p.m. *"Current Trends in Microbiology,*
MR. BENJAMIN KING, Columbus

3:15 p.m. *"Problems in Electrophoresis,"*
DAVID E. SMITH, M.D., Indianapolis

9:30 a.m. SECTION ON CUTANEOUS MEDICINE, Marion County General Hospital, Department of Dermatology

"Dangers of Prolonged Use of Methotrexate in Psoriasis,"
MALCOLM SPENCER, M.D., Danville, Ill.

"Local Treatment of Mycosis Fungoides with Nitrogen Mustard,"
PATRICK LOGAN, M.D., Indianapolis

"Some Problems with Long Term, Low Dose Tetracycline Therapy,"
WILLIAM MOORES, M.D., Indianapolis

"Anaplastic 'Pilar' Carcinoma Arising in Trichoepithelioma,"
WARREN W. EPINETTE, M.D., Indianapolis

"Bullous Pemphigoid in Childhood,"
JERE GUIN, M.D., Kokomo

"A New Treatment for Plantar Warts,"
STEPHEN PHELPS, M.D., South Bend

12 Noon — Luncheon, Marion County General Hospital
Election of Section Officers for 1972

12 Noon — SECTION ON OBSTETRICS and GYNECOLOGY, luncheon meeting, Card Room, Shrine Club (lower level)
"little babies, BIG IDEAS,"
RICHARD S. BAUM, M.D., Indianapolis, Director Neonatal Pediatrics, Methodist Hospital
Election of Section Officers for 1972

11:00 a.m. — SECTION ON DIRECTORS OF MEDICAL EDUCATION, luncheon meeting, Room B, Shrine Club (lower level)
"Community Health Sciences,"
RAYMOND H. MURRAY, M.D., Indianapolis, Chairman, Department of Community Health Sciences, Indiana University Medical Center
Election of Section Officers for 1972

12 Noon — SECTION ON COLLEGE HEALTH PHYSICIANS, luncheon meeting, Room C, Shrine Club, (lower level)
"College Health Physicians and the Indiana State Medical Association,"
Roundtable discussion chaired by WAYNE G. PIPPENGER, M.D., Muncie and JOHN M. MILLER, M.D., Bloomington
Election of Section Officers for 1972

(End of Section Meetings)

Wednesday Afternoon, October 13, 1971

1:00 p.m. — Meeting of Small County Delegates, Foyer, Candidates Room, Murat Temple
Time allowed to view technical and scientific exhibits, Lounge Room, Murat Temple

5:30 p.m. to 7:00 p.m. — President's Reception, Ballroom, Hilton Hotel

7:00 p.m. — Dinner, Hilton Hotel

Thursday Morning, October 14, 1971

8:00 a.m. — Board of Trustees breakfast meeting, Hilton Hotel

8:30 a.m. — Registration continues, Theatre Lobby, Murat Temple

8:30 a.m. — Opening of technical and scientific exhibits, Lounge Room, Murat Temple

SPEAKERS



RICHARD S. BAUM, M.D.
Indianapolis

Director of Neonatal Pediatrics, Methodist Hospital, Indianapolis; Fellow, American Board of Pediatrics; diplomate, National Board of Medical Examiners; former assistant in medicine, Children's Hospital Medical Center and instructor in pediatrics, Harvard Medical School; M.D. degree from Columbia University College of Physicians and Surgeons, 1959.



RAYMOND H. MURRAY, M.D.
Indianapolis

Professor of Medicine; chairman, Department of Community Health Sciences; director, Regenstrief Institute for Health Care; specialist in internal medicine and cardiology; M.D. degree from Harvard Medical School, 1948.

THE EXHIBITS

We urge you to visit with the exhibitors — they are here to help you — and to bring you the latest information. They contribute to financing your convention.

SPEAKERS

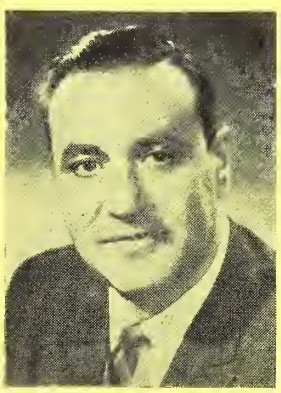


FRANCIS N. LOHRENZ, M.D.
Marshfield, Wis.

Practitioner in internal medicine; instructor, University of Minnesota, Department of Medicine; Fellow, American College of Physicians; M.D. degree from Vanderbilt University School of Medicine, 1949.

D. ROBERT HOWARD, M.D.
Durham, N.C.
Director, Physician's Associate Program, Duke University Medical Center; M.D. degree from University of Wisconsin Medical School, 1962.





MAYNARD IRWIN SHAPIRO, M.D.
Chicago, Ill.

Clinical Associate Professor of Medicine (Family Practice), Chicago Medical School; visiting lecturer, Graduate Program in Hospital Administration, University of Chicago Graduate School of Business; director of medical education, and of Department of Physical Medicine and Rehabilitation, Jackson Park Hospital; president, AAGP, 1968-69; chairman, 4th World Conference on General Practice; M.D. degree from University of Illinois, 1940.

Telephone Service

Special telephone lines will be installed at the convention again this year. You will be paged if you have your office call you at (317) 636-4974.

GENERAL MEETING

Ballroom, Shrine Club (upper level)

9:00 a.m. — Call to order by Malcolm O. Scamahorn, M.D., President, ISMA
Panel discussion on INCREASING THE MEDICAL OUTPUT
Moderator: Doctor Scamahorn
"Office System Improvement,"
FRANCIS N. LOHRENZ, M.D., Marshfield, Wis.
"Paramedical Personnel,"
D. ROBERT HOWARD, M.D., Duke University Medical School, Durham, N.C.
"Physicians' Responsibilities to Society and the Concept of the Medical Team,"
MAYNARD I. SHAPIRO, M.D., Chicago

11:00 a.m. — Meeting of 50-Year Club, Kaz Bar, Shrine Club (upper level)

12 Noon — President's Luncheon, Egyptian Room, Murat Temple
Presiding officer: Doctor Scamahorn
Invocation
Recognition of Fifty Year Club
Response: Arthur W. Records, M.D., Franklin
Presentation of Mental Health Award
Presentation of Public Relations Awards
Presentation of Community Service Award
Presentation of Scientific Awards
Speaker, EDWARD R. ANNIS, M.D., President, World Medical Ass'n

Thursday Afternoon, October 14, 1971

2:00 p.m. — Final meeting of the House of Delegates, Ballroom, Shrine Club (upper level)
Election of Officers
Meetings of Board of Trustees and Executive Committee immediately after adjournment of House of Delegates

2:00 p.m. — TOURS
(a) Indiana University Medical School
(b) Lilly Research Laboratories
(c) The Old Pathology Building (located on the grounds of Central State Hospital)

Auxiliary Program

President—Woman's Auxiliary to the Indiana State Medical Association—Mrs. Stanley M. Chernish (547-0513)
General Chairman of Women's Activities—Mrs. John N. Pittman (846-1766 and 846-8223)
President—Marion County Woman's Auxiliary—Mrs. Charles F. Gillespie (546-1822)

Tuesday, October 12, 1971

8:30 a.m. to 4:30 p.m. — Art and Hobby Show, Murat Temple
Come visit and help select the winners

9:30 a.m. — Registration—Indianapolis Hilton Hotel
Rolls and Coffee

12 noon — IMPAC Luncheon, Egyptian Room, Murat Temple
(Luncheon for physicians, their wives and guests)
Speaker:

2:15 p.m. — Board private cars for Tea at the home of Dr. and Mrs. Donald C. McCallum, 5610 E. 56th Street
Harpist—Mrs. Buckman Gardner

4:30 p.m. — Return by private cars to Hilton Hotel

8:00 p.m. to 10:00 p.m. — Panel Discussion on THE ACHIEVEMENT OF HAPPINESS,
Hilton Hotel Ballroom

Moderator: S. O. WAIFE, M.D., Indianapolis, Chairman, Commission on Convention Arrangements

"How to be Happy in 1971, though a Father,"
DR. LANDRUM BOLLING, Richmond, President of Earlham College

How to be Happy in 1971, though a Husband,"
JOHN I. NURNBERGER, M.D., Indianapolis, Chairman, Department of Psychiatry,
Indiana University School of Medicine

"How to be Happy in 1971, though a Physician,"
IRVINE H. PAGE, M.D., Cleveland, Editor, *Modern Medicine*

Reservations—Mrs. Richard A. Brickley (293-0907)
Hospitality and Registration—Mrs. James A. Crossin (253-1751)
Publicity—Mrs. Donald E. Wood (255-3933)
Door Prizes—Mrs. Paul Evans (849-1788)
Centerpieces—Mrs. Thomas S. Moore (846-9672)
Art and Hobby Show—Mrs. David Smith (849-5073) and Mrs. Harry Siderys (846-5030)

Wednesday, October 13, 1971

8:30 a.m. to 4:30 p.m. — Art and Hobby Show, Murat Temple
Come visit and help select the winners

9:30 a.m. — Registration—Hilton Hotel
Rolls and coffee

10:00 a.m. — Open Board Meeting, Woman's Auxiliary to the Indiana State Medical Association, Hilton Hotel, Mrs. Stanley M. Chernish, President, presiding.

11:00 a.m. — Social Hour

12 noon — Luncheon Hilton Hotel
"The Changing Patterns of Medical Illness,"
EPHRAIM T. LISANSKY, M.D., Baltimore, Md.

2:15 p.m. — Board buses at Hilton Hotel for a tour of the beautiful new INDIANAPOLIS ART MUSEUM at OLDFIELDS

4:30 p.m. — Return to Hilton Hotel

5:30 p.m. to 7:00 p.m. — President's Reception, Hilton Hotel Ballroom

Thursday, October 14, 1971

Morning free to shop

12 noon — ISMA President's Luncheon, Egyptian Room, Murat Temple

2:00 p.m. — TOURS
(A) Indiana University Medical School
(B) Lilly Research Laboratories
(C) The Old Pathology Building (located on the grounds of Central State Hospital)

Reports of Officers

Executive Secretary

As provided in the Constitution and Bylaws, the executive secretary is to make an annual report to the House of Delegates with, among other things, the actions taken by the previous House and disposition of those actions. Accordingly, herewith is the report of the resolutions adopted by the 1970 House of Delegates and their disposition.

Resolutions:

70-1 Which amended the Constitution and Bylaws to delete the mandatory Orientation Program. The action of the 1970 House had the effect of making this change in the Constitution and Bylaws and such change was recorded in the Constitution and Bylaws of the 1971 issue.

70-3 Calling for a study of the development of a Relative Value Schedule. This was referred to the Board of Trustees, who, in turn, referred it to the Commission on Medical Economics and Insurance, and their action is reported in their annual report to the House of Delegates of 1971.

70-4 Study and the appointment of a committee for the purpose of a fee-negotiating mechanism. The Board of Trustees referred this to the Commission on Medical Economics and Insurance and to the Commission on Governmental Medical Services and their action is reported in the annual report of these commissions to this House of Delegates.

70-8 Concerning insurance coverage for home health care. Was referred back to the Commission on Aging for further study and clarification as to implementation. No further action has been taken.

70-10 Calling for legislation to establish medical liability limits. Was referred to the Commission on Legislation. While this was studied, no definite solution by legislative route was found feasible; therefore, no legislation on this subject was introduced.

70-12 Support of Indiana Plan for Medical Education. This was referred to the Commission on Legislation, which did support the Plan, which was adopted by the state legislature.

70-13 Physical examination of school employees. This was referred to the Commission on Public Health and their action is reported to this House of Delegates in their annual report.

70-14 Support of Governor's Commission on Medical Education. Plan was referred to the Commission on Medical Education, who did support the proposal, and it became law.

70-15 Regarding semi-annual Meetings of the House of Delegates. Was referred to the Board of Trustees who, in turn, requested Dr. Wilhelmus, Chairman of the Finance Committee, and the Executive Committee to report on the estimate of cost and such report has been made to the Board.

70-16 Calling for resolution to create a Medical Department in the Board of Corrections. Was referred to the Commission on Legislation and a bill was introduced into the legislature but failed to pass, as it has for the past several years.

70-17 Calling for the executive secretary to make an annual report of the disposition of the previous House actions. Was requested in the 1970 session of the House of Delegates and this report constitutes carrying out of this resolution.

70-18 Reporting of AMA delegates' positions on issues. Was referred to the AMA delegation.

70-19 Hoosier Teen Health Happening. Was referred to the Board of Trustees who discussed this with the president and, inasmuch as facilities were not available for a repeat of this event during the year 1971, it was decided not to hold such a session at this time.

70-20 Licensing of medical assistants. This was referred to the Commission on Medical Education and Licensure who prepared a bill which was introduced in the 1971 session of the legislature and then withdrawn because of the opposition to such a bill at this time. Further details may be found in the annual report of the Commission on Medical Education and Licensure.

70-21 Dealing with inequities in dues payments. This resolution had the effect of amending the Bylaws to provide that physicians becoming a member for the first time after July 1st pay only half dues. Was adopted, and the resolution as written constituted a change in the Bylaws effective January 1, 1971.

70-22 Calling for a poll of the membership on abortion. While rejected by the House as written, it was referred to the Board of Trustees for their consideration on conducting a straw vote on liberalizing abortion laws and the AMA policy on abortion. Such a survey was accomplished with 59.6 of those replying saying liberalize; 36% said no; .004% no opinion. The question as to whether the membership agreed with the AMA position on abortion, 66.2% said yes; 27% said no; and .068% no opinion. The number of doctors replying to the poll was 49.5% of the membership.

70-23 Financing of renal dialysis program. This was referred to the Commission on Legislation. Such a bill was introduced in the 1971 state legislature and became a law.

70-24 Standards of non-medical drugs. This matter was referred to the Commission on Public Health and they deal with their disposition of this resolution in their annual report to this House.

70-28 Endorsement of Indiana Plan. This was referred to the Commission on Medical Education and Licensure and the report on this resolution is contained in their report to this House of Delegates.

70-29 Dealing with hazards of glass doors. Was referred to the Commission on Legislation to draft a bill on this subject. It was introduced and died in committee, but the Administrative Building Council has assured us that they will write measures concerning this hazard.

70-30 Uniform Ambulance Code. This was referred to the Commission on Legislation and a bill was drafted by the Board of Health on this subject and was introduced in the 1971 session of this legislature but the bill failed to pass, reasons being given were five million dollars appropriation to operate; and the objection of funeral directors and volunteer fire departments who operate ambulance services.

70-31 The Indiana Plan, calling for the endorsement of the plan. This was done and successfully passed the 1971 State Legislature.

70-32 Dealing with foreign medical graduates. This resolution was referred to the trustees who, in turn, referred it to the Commission on Legislation and drafted a bill, known as House Bill 1260, which was introduced in the 1971 General Assembly and became law.

70-34 Health certificates for re-licensing of certain individuals. Referred to the Commission on Legislation and no action was taken.

70-35 Calling for defining blood as a service rather than a sale. Was referred to the Commission on Legislation. A bill was drafted to provide blood as a service but in addition human organs and transplants were also defined as a service and not as a sale. The bill was introduced in the 1971 General Assembly and became law.

70-36 Calling for legislation on blood transfusions. This was also referred to the Commission on Legislation and made a part of the bill described in resolution 70-35 and became law.

70-38 and 70-39 Were combined by the House to adopt a substitute resolution calling on the Commission on Public Health and Commission on Legislation to pursue the matter of environmental pollutants. Referred to the Commission on Legislation, who devoted almost two months' discussion with members of the legislature and other interested parties on this subject. A Bill was drafted and introduced in the 1971 session but only a watered down version was adopted.

Membership

Last year your secretary reported on membership matters, pointing out that the gain for the period from July 31, 1969, to July 31, 1970, showed only a net increase of five. Thinking you might be interested in a 10 year comparative report, in 1960 there was a total of 4,620 physicians with 4,309 of them being members of the Indiana State Medical Association. As of 1970 there are 5,274 physicians listed as being in Indiana, of whom 4,505 were members of the association. Doctors engaged in patient care in 1960 totaled 4,228 and 4,638 in 1970. These figures are broken down as follows: Office based practice: 3,624 in 1960 against 3,909 in 1970. General practice: in 1960; 1,764, and, in 1970, 1,558. Medical specialties show 456 in 1960 and 584 in 1970. Surgical specialties: 1,056 in 1960 and 1,059 in 1970. Other specialties: 366 in 1960 and 708 in 1970. Hospital based practice: 586 in 1960 and 729 in 1970. Full time physician staff: 206 in 1960 and 236 in 1970. Other professional activities (which includes faculty, research, etc.) showed 186 in 1960 and 346 in 1970. Inactive: 206 in 1960 and 286 in 1970. On the basis of these figures, in 1960 93.27% of all doctors in the state of Indiana were members of the Indiana State Medical Association and in 1970, of the total number of physicians, 85.42% were members of the association.

It is probably time that perhaps county medical societies might consider reviewing the total number of physicians in their county and making a strenuous effort to take into membership those who are eligible and desirable. The Field Service of the association will be happy to assist county societies in this effort, if the county societies desire to avail themselves of their services.

The Executive Committee and the Board of Trustees have both had a busy and eventful year, particularly with the rapid change taking place in third party medicine. I would urge all members to read the reports very carefully.

CHAMPUS

The association has concluded its fourteenth year as fiscal administrator for the CHAMPUS program (Civilian Health and Medical Program of the Uniformed Services in Indiana). The operation continues to grow at an amazing volume and has reached a multi-million dollar operation. During the year of 1970 $1,384,353.05 was paid for this program in the state of Indiana. Compensation to physicians for professional services is made in the concept of usual and customary fees under medical peer review control. Federal officials have cited the Indiana operation as a model throughout the nation. A very small percentage of the claims received today are such that they are reviewed by the five-member review committee. In January 1971 the Department of Defense severed the program from HEW, inasmuch as the usual and customary fee administration and payment is made solely on profiles of charges by Indiana physicians. We are not expected to hold the 75th percentile as are other government programs in operation in this state.

Field Service

Following the close of the 1970 annual meeting, the three members of our Field Staff began an intensive campaign of visiting members of the 1971 state legislature in an effort to discuss with them many of the legislative matters in which the association had an interest. These men served as our representatives in the state legislature during the entire session, which precluded their work in the field with the county and district medical societies. However, they have worked diligently in attempting to visit each society in their respective districts at least once during the year.

Public Relations

Many times one has the opinion that the members of this association have little realization of the many daily activities carried out by the organization at the state level. Listed below are some of the areas in which the ISMA has, in a public relations sense, worked with people. This should give the membership an idea of activity in a variety of areas, which are separate from the projects and considerations of the Commissions and Committees, the Board of Trustees and the special committees which during the year worked in different project areas, all of which were staffed and coordinated through the Headquarters Office.

1. Provided information on Indiana law pertaining to foreign physician licensure in Indiana to individuals, universities and other states.
2. Information to students who wish to enter medical schools.
3. Provided filmstrip on Medicredit to societies.
4. Provided AMA with information on Commissions of ISMA.
5. Provided AMA News with material pertaining to ISMA and newspaper clips on a periodic basis.
6. Provided other Associations with information and materials on Medicredit.
7. Updated orientation kit for use by field staff in contacting new Indiana physicians.
8. Provided Hoosier Teen Health Happening video tapes to IU-PUI for use on their television network and for use on local cable television networks in Indiana.
9. Provide ISMA policy statements on smoking to various agencies.
10. Information on sex education for Conference on Human Sexuality.
11. Provided material and information on Physician's Assistants programs throughout the nation.
12. Continued to circulate HTHH films and tapes.
13. Provided information on abortion and abortion laws throughout the country.
14. Assisted out-of-state physicians in acquiring information on Indiana licensure laws.
15. Provided kits and materials on drugs and drug abuse to students, teachers and physicians.
16. Conducted 7th annual Journalism Awards program.
17. Provided materials to health teachers for development of health and safety files for teaching purposes.
18. Provided many materials on a variety of health subjects for research papers.
19. Provided local societies wishing to develop local public relations programs with materials to implement such programs.

20. Assisted societies in procuring films and speakers for meetings.

21. Assisted in promotion of district meetings.

22. Promoted all programs of the Association and the Annual Convention through appropriate flyers and publicity.

23. Provided news stories and background information to the news media on Association activities and policies.

Annual Convention

While the Annual Convention of the Indiana State Medical Association continues to be a highlight of the association activities, in which the matters that have been discussed by the various commissions and committees are picked as policy or are rejected, your secretary cannot help but sound a note of discouragement to the membership concerning our annual meetings. He has attended two meetings with the Pharmaceutical Manufacturers Association to discuss the lack of participation by pharmaceutical firms as exhibitors and advertisers in our state *Journal*. The trend, at this point, seems to be that the day of the exhibit hall during an annual meeting will be short lived. He has learned in the meetings with other states that many of them have completely done away with their commercial exhibits and have gone to a registration fee in order to defray the expense of the annual convention. In Indiana there has been for the past several years, as in all other states, a consistent drop in the number of exhibitors and in the amount of exhibit income. Whether this has stabilized remains to be seen, but if the trend continues, and if the association continues to propose an annual convention, other means may necessarily have to be found to finance this activity, whether it be by dues increase with a specific allocation made for the conduct of the annual convention, or whether it be done by a registration fee, hoping that this will meet the expense which annually runs better than $20,000 for payment of the speakers' honorarium and travel, rentals and other factors necessary to make the convention a success.

Physicians on AMA Councils and Committees

Neal E. Baxter, M.D.—Council on Occupational Health; Committee on Aerospace Medicine.

Roy H. Behnke, M.D.—Residency Review Committee in Internal Medicine

Norman R. Booher, M.D.—Council on Voluntary Health Agencies.

Wallace D. Buchanan, M.D.—Inter-Specialty Committee; Chairman, American College of Radiology.

Ross L. Egger, M.D.—Advisory Committee on Continuing Medical Education.

John S. Farquhar, M.D.—Chairman, Emergency Medical Services Committee.

Sprague H. Gardiner, M.D.—Committee on Health Care of the Poor; Chairman, Committee on Maternal and Child Care; Delegate, Section on Obstetrics and Gynecology.

Frank H. Green, M.D.—AMA Disability Insurance Claims Review; Committee on Private Practice.

Lester H. Hoyt, M.D.—Pathology Exhibit.

Charles A. Hunter, M.D.—Residency Review Committee of Obstetrics-Gynecology

Lall G. Montgomery, M.D.—Delegate, Section on Pathology

Myron H. Nourse, M.D.—Alternate Delegate, Section on Urology; Residency Review Committee for Urology.

Guy A. Owsley, M.D.—Chairman, Council on Medical Service, Liaison Representative Blue Shield Board of Directors.

Frank B. Ramsey, M.D.—President, State Medical Journal Advertising Bureau.

Lowell H. Steen, M.D.—Committee on Community Health Care.

Donald E. Wood, M.D.—AMA Board of Trustees.

Election of Secretary to Office in Forum for Medical Affairs

Your secretary was again elected Secretary-Treasurer for the 18th consecutive year for the Forum for Medical Affairs sponsored by the Presidents and Officers of State Medical Societies. This group conducts an annual meeting immediately preceding the opening session of the annual AMA House of Delegates meeting and is the largest attended single meeting held during the AMA annual session.

The Year Ahead

The association and its officers and staff are facing many new and challenging problems during the coming year. The amendment to the Constitution of the State of Indiana now providing for annual sessions of the state legislature raises a question as to whether we will continue to pull in our field staff from their other responsibilities in the field for this activity or whether we should consider staff expansion of a person wholly responsible for the legislative activity of this association. It is necessary that a person be on hand at all times during the legislature to watch for events, committee procedures, etc., that many times result in one not recognizing the original bill when finally passed. In addition to this, the individual legislator has little to say concerning bills that might be introduced. Heretofore the association came up with a proposal that its legal counsel write the bill and then obtain members of the House or Senate to agree to sponsor such legislation. In 1972, for example, it is now necessary to file with the Legislative Council an outline of your bill and this is done in September. The Legislative Council then prepares the bill and pre-files it with the Speaker of the House or President Pro-Tem of the Senate, and sponsors of the bill are selected. It is anticipated that in 1971, by November 15, bills will be assigned to various committees of the House and Senate and committee meetings may be held on these issues although the legislature does not officially convene until January. Therefore, legislative activity becomes a 12-month, year around activity. It is the belief of your secretary that additional staff for this purpose will be needed with the field staff serving as back-up men in case of an emergency.

In the past year the association has seen the Society of Internal Medicine move its affairs into the headquarters building, using the facilities of the building for the meetings of their Board and other business affairs. The same is true of the Indiana Roentgen Society, as they are utilizing the facilities of the office for distribution of materials to the members, although they have not physically moved their records into the headquarters building.

The services of the association have been offered to county medical societies for the purpose of assisting them in sending out notices of meetings, distributing minutes of their society meetings and use of these facilities has greatly increased by the installation of the WATS line and a 24-hour recording service.

If these activities continue to show growth, there will be an urgent requirement for additional staff to handle these matters with dispatch.

Your secretary would envision that, with the many additional problems which are facing your organization today, with the amount of research required in providing the membership with similar information, with the increasing programs of the various commissions and committees, additional staff will be required if we are to keep abreast of this increased activity.

The headquarters building has continued to serve as a meeting place for all branches of medicine and for your commissions and committees as well as the Women's Auxiliary. The building you have, in my opinion, is a priceless asset which serves the association members very well.

In projecting thoughts for the future, your executive secretary pinpoints some of these areas as being the supply and demand imbalance of physicians, especially

in the more rural areas of the state; the rising costs of health care and the continuing efforts by groups and individuals (in most cases other than the profession) to hasten the delivery of health care on a capitation basis, which, in essence, would provide physicians' services on a salary basis rather than a fee-for-service basis.

Other areas of concern are the increase in malpractice litigation, which has many serious implications for the physician and the patient in the delivery of health care; increasing chiropractic infiltration into the ranks of all legitimately recognized medical service ranks; and continuing medical education with the ever-increasing need for every physician to keep current.

Still another is the internal dissension and disunity which is causing considerable upheaval, perhaps less in Indiana than in other parts of the nation; nevertheless it is a growing problem which must be resolved if organized medicine is not to be splintered more than it is, and, I might add, much to the delight of its opponents.

These are problems which must be faced now. The day of leisurely thought and transition is gone forever. The ISMA must somehow streamline its procedures to act more quickly and responsively to the demands being made on it—not necessarily to acquiesce to these demands, but to present alternatives in the delivery of medical care which would confront third-party plans and would be controlled by the profession.

I have a firm belief that most of our members do not know of the many activities which are conducted by the ISMA and the American Medical Association to support them. There is an enormous communication blank between the individual member and his knowledge of the goals his state and national organizations are trying to achieve for him. The ISMA must improve this internal "blackout" in the interest of maintaining more unity and a more solid front against third-party interests who believe they know more about the practice of medicine and the delivery of health care than the physicians themselves do.

The ISMA membership must recognize that government and other organizations, in this period of rapid transmittal of ideas and the incorporation of those ideas into the changing patterns of everyday life, are "gearing up" every day to meet the challenges and enhance their own positions. The ISMA must recognize the necessity to do this, too, to compete effectively.

In addition to the need for more effective transmittal of facts and information to members, the Indiana State Medical Association should also recognize the need for a comprehensive ongoing public relations program utilizing all of the state's communications media on a regularly scheduled basis.

Involvement here would include the development of such materials as thirty and sixty second visual spot announcements for television, audio tapes and recordings for radio, advertising for the state's weeklies and daily newspapers, development of 15-minute and 30-minute features on Indiana State Medical Association programming and policies for radio and television, and the recognition that there are accompanying technical skills required in the production of such materials.

To launch such an approach to the public through the mass media would call for an outlay of approximately $25,000 in funds from the Association's annual budget to place such a program into operation, which heretofore has never been recognized, at least in the sense of a continuous annual effort. It would be in the best interest of the profession in Indiana. The entire format of such materials could be formulated under the guidance of the appropriate Commission of the Association and the Board of Trustees with the aid of staff, who are skilled, experienced and educated in the development of such materials.

The ISMA cannot afford at this time in history, to turn over to other organizations its own responsibilities in any one of the suggested problem areas which I have outlined.

ISMA must have the manpower, the knowledge and the capability of delivering

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INDIANA STATE MEDICAL ASSOCIATION

Statement of Financial Condition at August 31, 1971

ASSETS	General Fund	Journal Fund	Building Fund	Medical Defense	Student Loan	TOTAL ALL FUNDS
Cash in banks—operating	$ 91,634.50	$ 3,663.71	$ 2,901.35	$ 8,175.35	$ 750.42	$107,125.33
Cash in banks—interest bearing	—	—	6,133.53	—	19,019.78	25,153.31
Short term treasury bills	198,061.25	—	—	—	—	198,061.25
Accounts receivable	5,771.59	6,093.48	—	201.87	103.38	12,170.32
Prepaid expenses	6,148.54	200.00	3,349.51	—	—	9,698.05
Long term investments	83,452.63	—	—	25,112.59	20,810.00	129,375.22
Property—less reserve for depreciation	17,903.92	—	417,643.74	—	—	435,547.66
Intra funds accounts receivable	16,417.53	—	62,759.24	1,881.58	—	81,058.35
Total Assets	419,389.96	9,957.19	492,787.37	35,371.39	40,683.58	998,189.49
LIABILITIES AND FUND BALANCES						
Accounts payable	12.00	—	510.99	—	—	522.99
Due to Champus	2,478.26	—	—	—	—	2,478.26
Payroll taxes accrued	86.69	—	—	—	—	86.69
Property taxes accrued	1,896.72	—	25,888.70	—	—	27,785.42
Dues payable AMERF	19,695.00	—	—	—	—	19,695.00
Non-interest-bearing notes	—	—	21,625.00	—	—	21,625.00
Advances AMA	10,033.71	—	—	—	—	10,033.71
Deferred dues income	125,141.52	—	—	—	—	125,141.52
Intra funds accounts payable	61,516.82	19,541.53	—	—	—	81,058.35
Total Liabilities	220,860.72	19,541.53	48,024.69	—	—	288,426.94
Fund balances October 1, 1970	187,559.21	—	443,883.28	31,788.63	40,000.00	703,231.12
Profit (Loss) 11 months	10,970.03	(9,584.34)	879.40	3,582.76	683.58	6,531.43
Fund Balances at 8/31/71	198,529.24	(9,584.34)	444,762.68	35,371.39	40,683.58	709,762.55
Total Liabilities and Fund Balances	419,389.96	9,957.19	492,787.37	35,371.39	40,683.58	998,189.49

effective programs and plans which can "block" publicity-seeking schemes in the delivery of health care as well as counter bureaucratically formulated medical care plans, which at this point in time have met with little "hard line" resistance or effective alternative and innovative suggestions for organized medicine.

As I enter my third decade of service to your association and the profession, I am acutely aware of the massive challenges confronting the private delivery system, and I am enthusiastic rather than discouraged or fearful over your forward thinking, determined proposals to meet these challenges. This is a time for leadership and courage which are characteristic of physicians. I hope that we of the staff may worthily contribute to your exercise of these qualities of your profession.

JAMES A. WAGGENER,
Executive Secretary

The Treasurer

Inasmuch as the audit for the fiscal year ending September 30, 1970, has been published in *The Journal*, I will not repeat it with this report. Instead my report will deal with our financial status as of August 31, 1971.

The balance sheet on the preceding page reflects all funds except the Kitchen Fund, which has a bank balance of $5,700.09, the Ethel Gastineau Fund, with a balance of $24, and Dues Deposited in August to Be Distributed in September, with a balance of $1,051.

The net of income and expense for the General and *Journal* funds is running about as projected by the budget, and should be close to a break-even point for the fiscal year close.

The Executive Committee and the Board have regularly reviewed the financial statement and the investment account at each of their meetings and the Treasurer has followed the recommendations of these bodies by investing all available cash in short term bills or savings accounts in order to earn as much interest as possible.

The distribution of dues and the general ledger accounting for all funds has been successfully converted to a computer system during the year.

The certified audit for the fiscal year ending September 30, 1971, will not be concluded in time for this report but will be published in an issue of *The Journal* as soon as possible following its receipt.

LESTER H. HOYT, M.D., *Treasurer*

Chairman of the Board

HIGHLIGHTS OF BOARD ACTIVITIES DURING 1970-71

1. Donald E. Wood, M.D., of Indianapolis, was endorsed by the Board of Trustees to run for the office of trustee of the American Medical Association. With this endorsement and the work of the Indiana delegation to the AMA, a successful campaign was conducted for Dr. Wood resulting in his election in June to this high office in the organizational structure of the AMA.
2. A study of the need for physician's assistants was launched by the Board under the direction of Peter R. Petrich, M.D., president-elect of Indiana State Medical Association. Object of the study was to determine need, whether physicians would utilize this type of service, and the type of training such a program should encompass.
3. Thirty resolutions and several additional reports of the Board of Trustees to the 1970 House of Delegates were referred to Commissions and Committees of the Association for report back to the Board with recommendations and/or implementation.
4. The Board rejected the request of Regional Medical Programs to endorse a comprehensive survey of each physician's practice in Indiana.
5. Representatives of the Board were sent to national meetings on foundations for medical care and peer review with instructions to report back to the Board on material and information from the meetings.
6. In view of 66% of the membership replying to a survey indicating interest in tours sponsored by the Association, the Board authorized the Executive Committee to study such tours and make recommendations to the Board concerning ones which would have possible interest for Indiana State Medical Association members. Automobile insurance coverage as well as auto leasing for Indiana State Medical Association members are also being investigated upon authorization of the Board.
7. The Board was kept abreast of Commission activities throughout the year through reports of their activities. Commissions investigated such matters as foundations, malpractice insurance, additional insurance programs for the membership and a broad variety of topics of current concern to the profession, as is reported in their statements to the House of Delegates for 1971.
8. Many fiscal matters were deliberated by the Board, including additional budgetary requests from Commissions, rental of the Association's Pennsylvania Street properties and current financial status of the Association.
9. Because of the quality of the efforts of Indiana Health Careers, Inc., in directing youth into the many such careers in Indiana, the Board authorized a $500 contribution to this group for 1971.
10. The Board-sponsored Ad Hoc Committee on Maternal and Child Care Problems (composed of practicing physicians) kept the Board abreast of its activities in the vital area of reducing infant mortality. The committee, with the help of supporting funds and a grant to the Indiana State Medical Association, has a staff working with the committee to assist in accomplishing its objectives.
11. The Board's Ad Hoc Committee on Relationships with Blue Shield had not, at the writing of this report, submitted a final report. The committee, which met three times in different sections of the state, had scheduled final meetings in June to conclude its investigations and subsequently make recommendations to the Board.
12. Every meeting of the Board heard discussions of national health insurance plans, Health Maintenance Organizations, Peer Review, Medicare and Medicaid. Periodic reports also were made by the dean of Indiana University School of Medicine and the state's commissioner of health.
13. The Board moved that the office of Speaker of the Indiana State Medical Association House of Delegates be studied by the Commission on Constitution and Bylaws.
14. A section in *The Journal* for scientific papers on medical specialty subjects was authorized by the Board of Trustees.
15. Proposed legislation on feed lots and environmental control was discussed by the Board. Features of the bills were studied and several recommendations were made for amending these bills. The Board adopted these recommendations. The Board was also kept abreast of other legislation being observed and supported or not supported by the Legislation Commission.
16. Dr. Scamahorn, president of the Association, reported to the Board on the successful Leadership Conference

which had been held in the headquarters office and suggested that everyone who would in the future have an opportunity to take this course, do so.

17. The Board approved continuing the annual faculty—medical student—Indiana State Medical Association representative retreat. This retreat is held to exchange information between these three groups in the interest of keeping current with educational attitudes and recommendations by all three groups.

18. The Regional Medical Program's structure and activities were discussed throughout the year by the Board, with some members of the Board suggesting that the Indiana State Medical Association withdraw support of this group. The Board did vote to divorce itself from any relationship with Indiana RMP programs but then reconsidered the issue, pending the meeting of the executive committees of Indiana State Medical Association and RMP.

19. It was the recommendation of President Scamahorn that a second Hoosier Teen Health Happening not be held during 1971, because of the lack of available dates and adequate facilities in Indianapolis. He requested, however, that the budget for such an event be held in abeyance pending a time in the future when such a program might be held again.

20. In view of the approaching meeting of the Indiana General Assembly and its concern with many issues of health, including the matter of abortion, there was considerable discussion on the subject. A poll was taken of the membership to determine their attitudes in this area and, upon receipt of the results of the poll, the Board felt that as small a circulation of these results as possible should be made. This action was taken to avoid publicity on the results which might be misinterpreted by the public. It was generally accepted that the Indiana State Medical Association (1) tabulate and file the report with the various commissions and committees of the Association who were involved and interested, (2) that the State Association take no position on this controversial issue, and (3) make it clear to the individual members of the Association that they were free to lobby for or against such a bill in accord with their own desires.

21. The Board also moved that a resolution be prepared instructing the Board of Medical Education and Examination to encourage duly licensed physicians to practice in areas of greatest need. This action was taken in view of concerned lay groups in the licensing of foreign physicians.

22. Mr. Kilborn, president of Blue Shield, reported on parameters which were to be used for all Medicaid services. The parameters, in effect, were limitations on office calls, home visits, nursing home visits, injections, in-hospital medical visits, and other medical procedures under the Medicaid program. The Board approved these parameters contingent upon recommendations of the Commission on Medical Economics and Insurance. Following a study by that commission, the commission recommended rejection of the parameter policy, completely, and so forwarded their recommendations to the Board, which adopted the recommendations.

23. Blue Shield officials periodically reported to the Board throughout the year. Within the framework of these reports, it was pointed out that Blue Shield had increased from $47 million to $62 million in regular business during the year of 1969-70. The amount of their government volume increased from $32 million to $46 million during the same period.

24. Concerning the health insurance program for Indiana State Medical Association membership, and based upon the request of several physicians to increase the amounts of benefits, rates were increased and the Board so moved that these rate increases be adopted. Professional health security plan was raised from $7,500 to $25,000 and the $15,000 lifetime maximum benefit was increased to $50,000.

25. AMA delegates were invited to meetings of the Board throughout the year to keep the Board informed of activities at the AMA level.

JOE DUKES, M.D. *Chairman*

First Trustee District



GILBERT M. WILHELMUS, M.D.,
Trustee

The annual meeting of the First District Medical Society was held May 6, 1971, at the Petroleum Club in Evansville. The meeting was attended by over 140 members and their wives. Dr. Joe Dukes, chairman of the Board of Trustees, and Dr. Malcolm Scamahorn, president of the Indiana State Medical Association, were in attendance. Mead Johnson & Company hosted our social hour preceding the dinner. Dr. Peter Olch from the National Historical Society of Washington, D.C., gave an entertaining talk on the life and history of Dr. Halstead. Dr. George W. Willison, former Blue Shield board member, and Dr. Willard Barnhart, present Blue Shield board member, reported to the group. Gilbert M. Wilhelmus, M.D., reported the past and present business activities of the Indiana State Medical Association—as well as local activities. Dr. Malcolm Scamahorn gave a summary report of the last legislature's activities which affected the Indiana State Medical Association. During the meeting the following officers were elected:

Raymond Burnikel, M.D., President
Bernard Rosenblatt, M.D., Vice-President
William Dye, M.D., Oakland City, Secretary-Treasurer
Gilbert M. Wilhelmus, M.D., Trustee, First District (re-elected)

The physicians in the First District have worked diligently this past year in many fields. In the spring of 1971 at the Blue Shield Seminar, Dr. Patrick Corcoran was on the panel to discuss the Vanderburgh County Foundation. Dr. George W. Willison was given a special plaque for his 12 years of service on the board of the Blue Shield.

Several physicians attended the Medical Student-Physician's Retreat at French Lick and their comments have been excellent in regard to this. They feel that the medical students of today are well informed. In their opinion, knowledge was transferred bilaterally.

The Vanderburgh County Medical Society, under the chairmanship of Dr. Bloss, had a sports seminar at which there was a total enrollment of over 100 coaches and physicians. Besides the local physicians on the panel there were other outstanding people from the sports world: Leslie Bodnar, M.D., University of Notre Dame; George Rapp, M.D., Indianapolis Capitols Football Team; W. D. Paul, M.D., University of Iowa; Mr. Kent Falb, Detroit Lions.

The Indiana State Medical Auxiliary, under the leadership of Mrs. Paul Clouse of Evansville, had their State House of Delegates Meeting in Evansville. Their program was a great success with many of the physicians' wives from over the entire state in attendance.

Medical education is in the forefront in

our area as it has been in the past. Dr. Patrick Corcoran was appointed the Medical Education Director for the Indiana University program. Even though "Pat" is doing this part time, he has curtailed his large practice to give appropriate time and energy to this endeavor. I am certain the medical students will appreciate his strong efforts in medical education in Evansville. There has been an excellent program for their education planned for the future. Medical education in the First District is continuing with many weekly meetings, seminars, and CPC's. The Vanderburgh County Foundation, which has been in existence for approximately 10 years, is getting more stimulation because the Foundation idea is moving to the Mid-West.

The Trustee wishes to thank the many members of the District for their cooperation and activities in their local Medical Societies, and for their participation in the functions of the Indiana State Medical Association. It is a pleasure to see so many of the local physicians on various committees and commissions going to our state headquarters to attend the meetings.

GILBERT M. WILHELMUS, M.D., *Trustee*

Second Trustee District



JOSEPH E. DUKES, M.D., Trustee

The Second District Medical Association held its annual meeting at the Elks Country Club May 27, 1971.

Dr. Snyder, president of the Second District, opened the business session and gave a short message of welcome. A resolution by Dr. Chattin of Vincennes stated that mandated committees should be compensated at a rate of $50.00 per hour. This resolution was to stir thought and did not especially want action at this time.

Dr. J. S. Brown of Carlisle was given special commendation for his 49 years of service as secretary of the Second District. He was then elected for his fiftieth term.

Dr. Joe Dukes was again elected a director of Blue Shield.

Dr. Betty Dukes was re-elected alternate trustee of the Second District.

Dr. Scamahorn gave a short speech on legislation.

The feature speaker for the evening was Dr. Roger Newton of the Mead Johnson Research Center. His message concerned drug abuse.

This meeting was very well attended and was considered one of best district meetings in the past several years.

The next meeting will be hosted by Greene County.

JOSEPH E. DUKES, M.D., *Trustee*

Third Trustee District



ELI GOODMAN, M.D., Trustee

The Third District held its annual meeting at the Robert E. Lee Motel in New Albany, Indiana on April 7, 1971, with Floyd County Medical Society as the host group and Dr. Daniel Cannon presiding. The guest speakers were Dr. and Mrs. J.C. Willke of Cincinnati, Ohio. They discussed the Sex Education of Children and Adolescents from the viewpoint of a family physician and his nurse-wife. The headquarters of the Indiana State Medical Association was represented by Mr. Bob Amick who discussed the proposed Medical Legislation in the current session of the Indiana State Legislature.

In the election of officers, Dr. Daniel Cannon was re-elected president of the district and Dr. Charles McCalla of Paoli was re-elected secretary. Dr. Eli Goodman was elected trustee to replace the extremely capable Dr. Donald M. Kerr who had served two full terms and was not eligible for re-election.

Dr. Kerr gave a brief summary of his years of service as trustee.

There have not seemed to be any major intramural medical problems in the District during the current year. Your trustee apologizes for not having been able to attend county meetings in the District to this time but will make every effort to attend such meetings in the future.

The next District meeting will be held at the Marriott Inn in Clarksville on April 5, 1972. A program of "Gut" Issues is being planned under the leadership of Dr. Cannon. The various health care plans, peer review, and state and national aims and objectives will be dissected. I hope that as many as possible will attend this meeting.

ELI GOODMAN, M.D., *Trustee*

Fourth Trustee District



ROBERT M. REID, M.D., Trustee

As I submit this last of a series of singularly unexciting reports it would seem that after more than eight years in the role of Trustee I should have at least one or two significant comments. Unfortunately those things which occur to me now are observations previously and more effectively stated by my predecessors.

Generally, of course, one is concerned about the lack of interest manifest by ISMA membership. On my desk as I write this is a letter from the president-elect expressing concern that four of our several district representatives on various commissions have failed to attend *any* meetings during the year. These were individuals who had expressed willingness to work in their respective areas. Any trustee could point to many other examples of indifference.

In considering the causes obviously one must look first to the leadership. Reflecting on my several years of observation, I consider ISMA to be directed, for the most part, by a capable, highly motivated group who give a surprisingly heavy chunk of themselves during their extended tenure to innovate and carry out programs which they consider to be in the best interest of the membership. Further, I believe that there is a steady improvement in the quality and dedication of these individuals from year to year.

How then do we fail? A number of possibilities would be considered. The lack of any real power over the membership dilutes the need for attention to the organization, the heavy involvement of the physician members in the pursuit of their own obligations and interests, and the much discussed individuality of physicians all certainly play a part. I think, however, another less tangible factor must be considered important. I refer to the increasing political sophistication of our organization. There is such sensitivity to the wishes of any expressed opposition to the various activities of ISMA that many promising efforts are abandoned almost before they have been fully considered. Such opposition is frequently from small but articulate groups of physicians who apparently feel vulnerable in some situations. My attention is, no doubt, directed to this problem as a result of some of my per-

sonal experiences. I am impressed by the number of times I have been told regarding one effort or another, "Bob, old boy, we believe in you and we understand what you are doing, but we just can't take the heat from the membership." I wonder if some greater effort to acquaint our physician colleagues with the background and possible promise of new and sometimes different approaches might not stimulate more interest and, hopefully, progress. I don't believe that the fact that I speak defensively in this matter seriously detracts from the validity of the observation. I don't use this space or take your time to plead or martyr a cause but simply to reflect that this "federal" type of political orientation may be one of the things that has become uninteresting about our leadership.

I would like to congratulate the Dearborn-Ohio County Medical Society on an unusually well conducted district meeting in May of this year. The accumulation of a significant district treasury, the fact that there was a three-man race for Trustee and the interest expressed at the meeting all offer hope for the future of the Fourth District. Finally I wish to offer my support and good wishes to my successor, Jack Shields.

ROBERT M. REID, M.D., *Trustee*

Fifth Trustee District



WILBERT McINTOSH, M.D.,
Trustee

Our meeting was held the 14th of May at the Terre Haute Country Club. In the afternoon there was a business meeting which many dignitaries attended, including the president-elect and the chairman of the Board.

We also discussed improving attendance and our approach to this, which I think is significant for our area, is that we have made a $10 dues for our district meeting, which includes dinner. We are going to try this and see if it does help attendance. Doctor Wakiem, Director of the Terre Haute Medical Education Foundation was the speaker for the evening.

The next meeting will be held May 24, 1972.

WILBERT McINTOSH, M.D., *Trustee*

Seventh Trustee District



JAMES H. GOSMAN, M.D.,
Trustee

The president of the Marion County Medical Society, Dr. Donald E. Stephens, was elected president-elect of the Seventh District Medical Society at its annual meeting June 2 a the Martinsville Country Club. Dr. Stephens will succeed Dr. John M. Records of Franklin in 1972.

In other voting, Dr. Merrill M. Wesemann of Franklin was elected secretary-treasurer to succeed Dr. Stephens; Dr. John O. Butler, Indianapolis, was elected Seventh District trustee to succeed Dr. James H. Gosman of Indianapolis, who is candidate for president-elect of the Association, and Dr. Joseph F. Ferrara, Franklin, was elected alternate delegate to succeed Dr. Butler.

During the meeting, Dr. Ellery T. Drake of Martinsville, the outgoing President, complimented the Hendricks County Medical Society for its letter to the president of Blue Shield protesting the wording on some of its form letters mailed to patients, such as "fee not allowed." It was moved, and the motion carried, that the district society direct a letter to Blue Shield condemning the use of the statement "fee not allowed" and urging substitution of the phrase "not covered by . . . ."

After dinner, Dr. Raymond H. Murray of Indianapolis, director of the Regenstrief Institute and president of the Metropolitan Health Council, discussed "What's New in Health Delivery Systems."

At the conclusion of the meeting, Dr. Drake relinquished control of the meeting to Dr. Records who announced that the 1972 annual meeting of the Society will be held on Wednesday, June 14, 1972, at the country club in Franklin, and that Dr. Otis R. Bowen, Speaker of the Indiana House of Representatives, will be guest speaker.

JAMES H. GOSMAN, M.D., *Trustee*

Seventh Trustee District



DWIGHT W. SCHUSTER, M.D.,
Trustee

The Seventh District Medical Society held its annual meeting on June 2, 1971, at the Martinsville Country Club. There was a better than average turnout for the dinner, the business session and the scientific meeting. Dr. Ellery Drake presided. Guests included Dr. and Mrs. Malcolm O. Scamahorn, President of ISMA. Dr. Donald Stephens was elected president-elect and Dr. John Records began his term as president of the Seventh District. Dr. John Butler was elected trustee to succeed Dr. James H. Gosman, and Dr. Joseph F. Ferrara was elected alternate trustee to succeed Doctor Butler. Next year's annual meeting will be in early June 1972 at the Franklin Country Club.

Dr. Raymond Murray of Indianapolis was the after-dinner speaker. He made an excellent presentation of a complex subject, Federal Health Programs in Marion County.

On June 15, 1971, there was a general meeting of the Marion County Medical Society with a panel presentation on the subject of proposed and pending health service programs, including discussion of HMO's and Medical Society Foundations. More than 100 doctors, plus some hospital personnel, attended this meeting which was directed toward alerting physicians as to rapidly developing changes in the delivery of medical services.

The Seventh District Medical Society is proud to announce the candidacy of one of its outstanding members, Dr. James H. Gosman, for the office of president-elect of the Indiana Medical Association, subject to election at the annual meeting of the House of Delegates in October 1971.

DWIGHT W. SCHUSTER, M.D., *Trustee*

Eighth Trustee District



RICHARD INGRAM, M.D.,
Trustee

The 1971 annual meeting of the Eighth District Medical Society was held Wednesday, May 26, 1971, at the Portland Country Club. There was golf in the afternoon with several participants and prizes for the winners. In the early evening, a business meeting was held at which guests were present, including: Peter Petrich, M.D., and Mr. Howard Grindstaff of Indiana State Medical Association. The business consisted primarily of the election of

officers. The officers elected for the 1971-72 year were: president, Franklin K. Beeler, M.D.; and secretary-treasurer, Edward R. Bush, M.D., both of Anderson.

The business meeting was concluded after the election of officers, and a pleasant dinner was then held at which the wives of the members of the district medical society were guests. Following dinner, the speaker, Dr. Campbell, of Indianapolis, gave a very interesting and informative talk on the subject of venous bypass grafts for coronary artery disease. It was enjoyed by all and there was much participation in discussion following the talk.

In the past year, in the eighth district, there have been many points of concern regarding organized medicine. However, the foremost matter for concern is the threatening approach of national health insurance or government medicine. From discussion throughout the district for the past year, it has become apparent that physicians in this district feel that it's time for organized medicine to adopt a philosophical stand on the issue of government medicine to which they may repair and be able to defend.

Doctors in general feel that as we have compromised with government and the forces of socialization, we have been piecemeal giving away the freedoms of both ourselves and our patients. It is my impression that the doctors of this district now feel that it is time to adopt a positive statement of policy at all levels of organized medicine which will inform physicians, the general public, and the federal government as well exactly what our philosophical position is, and the length to which we are willing to defend it.

I realize that this may sound like strong medicine at a time when much of the public doesn't have a very high opinion of medical organizations in general. However, it seems that we have tried all available compromise approaches without significant success. In fact, consistently losing ground in our fight against socialized medicine.

Therefore, it seems that the only logical stand to take at this time is a positive statement of policy to which physicians concerned with the private practice of medicine may repair and be able to defend.

RICHARD INGRAM, M.D., *Trustee*

Ninth Trustee District



WILLIAM M. SHOLTY, M.D.,
Trustee

My first year as trustee has been informative. Interest by the county medical societies in the Ninth District in ISMA is increasing as more M.D.s are becoming aware of the forces at work to destroy the freedom of medical practice as we have known.

The Ninth District Medical Society met at the Lafayette Country Club on June 3, 1971. The host county was Hamilton with Dr. R. Adrian Lanning, county president, presiding. The meeting was held in Lafayette because of its central location in an effort to attract a larger attendance.

Golf and skeet shooting were enjoyed by those participating.

The scientific session was held at 2:30 p.m. Twenty to twenty-five members attended. The business session was held following the scientific session. The minutes of the previous meeting were read and approved. Dr. Max N. Hoffman was elected alternate trustee.

Dr. Malcolm Scamahorn, president of ISMA, discussed the legislation of the past General Assembly.

Dr. Robert Hedgcock offered a resolution requesting the ISMA to disassociate itself from the AMA. The motion was defeated.

The evening dinner and program was attended by 86 doctors, wives and guests. The program consisted of a trio of Purdue University Glee Club members and an address by Dean Earl Butz on "Practical Ecology."

A meeting is planned for the delegates prior to the annual ISMA meeting to discuss resolutions that have been proposed so the delegates can present a more or less uniform front.

As Ninth District trustee, I want to thank my counties for their interest and cooperation. As trustee, I am aware of the tremendous struggle medicine must wage in order not to become completely socialized.

WILLIAM M. SHOLTY, M.D., *Trustee*

Eleventh Trustee District



LOWELL J. HILLIS, M.D.,
Trustee

The meeting of the Eleventh Trustee Medical District was held on the third Wednesday in September 1970, at the Wabash Country Club. Dr. Lloyd Hill of Miami County was elected president; Dr. Fred Poehler of Wabash County was re-elected secretary-treasurer.

During the past year, the state president Dr. Malcolm O. Scamahorn visited the Huntington County Medical Society as a part of his so-called "whirlwind tour" of northeastern Indiana. The message that was brought by Dr. Scamahorn was well received by the members of the Huntington County Medical Society and this was deemed to be a highly successful and enthusiastic meeting.

The Cass County Medical Society sponsored a labor-organized medicine meeting in March 1971. This was a highly successful meeting presenting speakers for organized medicine and for the labor unions. This meeting was so well received in the community that it has since been repeated as a part of the functions of the Cass County Chamber of Commerce.

The 1971 meeting of the Eleventh Councilor District is scheduled at the Missisinewa Country Club at Peru on September 15.

This should be a great meeting. The committee has worked extremely hard and the highlight of the meeting is the speaker of the evening, Dr. Edward Annis, past president of the American Medical Association, from Miami, Fla.

Election for alternate trustee will be held at this meeting.

Otherwise, the attitude of the doctors in the Eleventh District has been "business as usual."

LOWELL J. HILLIS, M.D., *Trustee*

Twelfth Trustee District



WILLIAM R. CLARK, SR., M.D.,
Trustee

Our Annual Meeting was held May 19, 1971, at the Chamber of Commerce in Fort Wayne.

George Manning, M.D., president of the 12th District, presided. New Officers named were: George Manning, M.D., re-elected president; Frank Bryan, M.D., re-elected vice president; Brad Hughes, M.D., re-elected secretary-treasurer; and Walter Griest, M.D., elected alternate trustee.

The following guests were present: Thomas Terrell, M.D., AMA Alternate Delegate; Richard Ingram, M.D., Eighth District Trustee; Vince Santare, M.D., 10th District Trustee; Mr. John Walters, our field representative and Mr. Donald Van Dykes, vice president, Indiana Blue Shield.

Mr. Raymond Robillard, M.D., president of the Federation of Medical Specialists of the Province of Quebec, was the speaker of the evening. The subject of his talk was "Happenings of Organized Medicine versus State Medicine in the Province of Quebec." The information given by this well-informed, articulate speaker was well received and greatly appreciated.

The chief happening of the District was the tour of five of my eight counties, set up for Dr. Scamahorn and myself by Mr. John Walters, our field representative. The various counties held special breakfast, luncheon or evening meetings. This turned out very successfully, proven by the fine attendance of the physicians. There were only three absentees of the entire five-county membership. It was so well received that I have been asked by the county officers to duplicate the tour next year.

During the past year I have written synopsis reports of the proceedings of the State Board of Trustees which were mailed to the various county secretaries, who in turn, posted them on the hospital bulletin boards. This will be continued because of the great interest shown in this method of quickly getting to the membership the information of the proceedings of the Board of Trustees. I will also continue to make personal reports to the monthly meetings of the Ft. Wayne Medical Society board of trustees.

I want to thank the District officers and the physicians that are working on the various state commissions and committees. You are doing a yeoman job and I am very proud of your efforts in behalf of the District and organized medicine. I want to thank Dr. Fred Schoen, my retiring alternate. He has done an excellent job supporting me.

I, as your Trustee, along with the officers, and the new alternate trustee, Dr. Walter Griest, look forward to meeting these changing times of organized medicine. I will sincerely dedicate my efforts, not only towards the best interest of the District and ISMA, but also towards the national change in health services so that the physician will never lose his identity in patient care.

WILLIAM R. CLARK, SR., M.D.,
Trustee

Thirteenth Trustee District



OTIS R. BOWEN, M.D.,
Trustee

The 13th District Medical Society of the Indiana State Medical Association held its annual meeting on September 3, 1970, at the Elkhart Hotel. Although the attendance — as seems usual for afternoon district meetings — was rather slim, the quality of the program was excellent. Mr. Jack Holiday, Manager of Elkhart Clinic, Credentials Chairman of the American Association of Medical Clinics, spoke on "Foundation Medical Problems Anticipated in Elkhart County." This was followed by a talk on Blue Shield of Indiana's proposed Foundation Plan medical practice by Mr. Herbert Dixon. The last speaker of the afternoon presented a very interesting paper. He was Dr. Sam Packer, medical director of Ohio Permanente Medical Group of Cleveland. He spoke on experiences of physicians in foundation practice in the midwest — pros and cons. This was followed by a lively panel discussion, with questions from the floor.

The business meeting was then conducted, with 25 members present. The officers elected for 1971 were: George Haley, M.D. South Bend, president; Frank McGue, M.D. Michigan City, president-elect; John Hildebrand, Jr., M.D. South Bend, secretary-treasurer; Beach Gattman, M.D., Elkhart, alternate trustee.

We were privileged to have the President-elect of the ISMA, Dr. Malcolm Scamahorn, present. He gave a few remarks.

The dues for the district were discussed, and it was decided to leave them at $2.00 per physician per year.

A delightful dinner-meeting was then held in the Banquet Room of the Elkhart Hotel, and the speaker of the evening was Mr. Donald M. Newman, a pharmacist of Mishawaka who was at that time a candidate for Congress from the third Congressional District.

A hospitality room was available for the wives of the physicians during the afternoon. The hospitality room was maintained up until the dinner hour and was sponsored by the Wayne Pharmacal Supply Company.

Much time of the members of the 13th District was consumed in plans and preparation for the Indiana State Medical Association meeting in South Bend in October 1970.

At the present time, plans are being discussed for the September meeting of the 13th District Medical Society.

OTIS R. BOWEN, M.D., *Trustee*

Editor of The Journal

The financial accounts for the fiscal year show promise of running close to the budget. National advertising has been a few percentage points above that of last year. On the expense side there have been a few increases for such items as postage and clerical help.

The May issue this year, which was devoted almost entirely to the problems of drug abuse, has proven to be most popular and helpful. Special reprints of the drug articles, including the reference lists of literature on the subject, and bound with the prize-winning drug-poster cover, have been printed and distributed to all high schools and junior high schools in the state.

We have had an adequate number of good scientific articles. Of special interest was the symposium on the kidney transplantation team and its work at Indiana University.

The Journal's function as historian for the Association was represented by outstanding presentations on the history of medicine and medical education in Evansville and a personal account of the life and times of Dr. William Hutchings in Madison, written by a professional science writer, Mrs. Elisabeth Z. Kelemen. The historical series will be continued next year by a special issue on the early days of medicine in Vincennes.

Frank B. Ramsey, M.D.
Editor

Delegates to AMA

A concerted effort by the Indiana State Medical Association delegates and alternate delegates to the American Medical Association's 120th Annual Convention in Atlantic City, June 20 through 24, placed Dr. Donald E. Wood, Indianapolis, in an AMA Board of Trustees slot.

Doctor Wood, who was at that time serving as ISMA delegate, filled the vacancy of L. O. Simenstead, M.D., who was ineligible for re-election. His bid for the Board went unopposed.

Guy A. Owsley, M.D., Hartford City, was re-elected to the Council on Medical Service.

The ISMA delegation, working tirelessly, began each day with a 7 a.m. breakfast meeting, caucused several times during the week and was in constant contact with other delegations concerning the reports of AMA officers and the Board of Trustees, reports of the various councils and the 98 resolutions submitted by state societies throughout the nation. Altogether there were 158 items of business.

These were thoroughly reviewed by the delegation and decisions were made as to support or nonsupport, with each member of the delegation receiving reference committee and other assignments.

The Indiana delegation introduced three resolutions; one dealing with physician's liability for injuries resulting from substitution of drug products; another with release of information on Medicare and a third on substitution of medications other than that specified in physician's prescriptions.

The resolve on the liability resolution stated:

> "That the American Medical Association advise physicians that the proposed Drug Product Selection Authorization Agreement, proposed by the American Pharmaceutical Association, designed to over-rule existing laws against drug product substitution, will in no sense relieve physicians of their legal and ethical responsibilities to their patients; but rather that the signing of such agreements may complicate the physician's professional liability in the event that pharmacists defend themselves against patient injury suits by arguing that they were acting in accord with an agreement signed by the prescriber."

The resolution and the other resolution, which also warned of drug substitution efforts by the American Pharmaceutical Association, were adopted by the AMA House of Delegates.

The Medicare resolution was critical of the Department of Health, Education, and Welfare's and the Social Security Administration's "blatant infringement" on the physician's right to make medical decisions.

The resolution pointed out that these departments were becoming more and more critical of moneys expended for medical care and less concerned with the actual medical needs of each patient and the true costs of this care.

Resolution asked that this information be imparted to the public through the nation's media. Reaction of the reference committee was not to adopt the resolution but in so doing the committee expressed the sentiment that the AMA was already doing a "creditable job" in this area.

Delegates attending the meeting from Indiana were Eugene F. Senseny, M.D., Fort Wayne, chairman of the delegation; Jack E. Shields, M.D., Brownstown; John S. Farquhar, Jr., M.D., Fort Wayne; Doctor Wood; and Frank H. Green, M.D., Rushville.

Alternate delegates attending included Patrick J. V. Corcoran, M.D., Evansville; Thomas C. Tyrrell, M.D., Hammond; James A. Harshman, M.D., Kokomo, Eugene S. Rifner, M.D., Van Buren and Kenneth O. Neumann, M.D., Lafayette.

Assisting the delegation were Sprague Gardiner, M.D., Indianapolis, delegate from the AMA Section on Obstetrics and Gynecology; Lall G. Montgomery. M.D., delegate from the Section on Pathology and Physiology, and Myron H. Nourse, delegate from the Section on Urology.

In attendance for the Convention, too, were Malcolm O. Scamahorn, M.D., Pittsboro, president of ISMA; Peter R. Petrich, M.D., Attica, president-elect; Joe Dukes, M.D., Dugger, chairman of the Board; and Lester Hoyt, M.D., Indianapolis, treasurer.

In addition to studying, discussing in committee and acting on the items of business, the House of Delegates heard a stirring speech by the President of the United States as well as outlines of the future as seen by both outgoing and incoming Association presidents.

Meeting for a total of 13 hours and 53 minutes, the House acted on six special reports, 31 reports from the Board of Trustees, two from the Council on Constitution and Bylaws, four from the Council on Medical Education, eight from the Council on Medical Service, two from the Judicial Council, and one from the Council on Long Range Planning and Development, and 104 resolutions.

Elections

Charles A. (Carl) Hoffman, West Virginia, was chosen President-Elect of the AMA. Others elected or re-elected to Association positions were:

Vice President: Ralph C. Teall, California.

Speaker of the House: Russell B. Roth, Pennsylvania (re-elected).

Vice Speaker of the House: J. Frank Walker, Georgia (re-elected).

Trustees: John M. Chenault, Alabama (re-elected); Raymond T. Holden, Washington, D.C. (re-elected); John R. Kernodle, North Carolina (re-elected); Robert B. Hunter, Washington (to fill the unexpired term of Burtis E. Montgomery); and Jere W. Annis, Florida (succeeding Charles A. Hoffman).

Judicial Council: Henry I. Fineberg, New York (succeeding Renato J. Azzari).

Council on Constitution and Bylaws: Carroll L. Witten, Kentucky (re-elected); and John H. Burkhart, Tennessee (to fill the vacancy left by Robert Hunter's election to the Board).

Council on Medical Education: James W. Haviland, Washington (re-elected); and Bernard J. Pisani, New York (re-elected).

Council on Medical Service: C. Willard Camalier, Jr., Washington, D.C. (filling the vacancy of Charles J. Ashworth who was ineligible for re-election).

Address by Richard M. Nixon
President of the United States

President Nixon began with some general statements based on Disraeli's comment that "The health of the people is really the foundation upon which all their happiness and all their powers as a state depend," pointing out that "I am happy for this opportunity to salute this profession which has contributed so much to the health of the American people and to the strength of this nation."

He talked about the current debate on national health insurance, emphasizing that "I believe that the most expensive plan that has been offered—a plan for nationalized, compulsory health insurance—is the plan that would actually do the most to hurt health care in this nation."

Such a plan, the president said, "would exact a very high price from our people in terms of dollars and cents. But it would exact an even higher price in terms of the quality of American medicine."

Mr. Nixon emphasized that America's health care system needs reform. But he added that "We can never improve our country's medical system by working against our country's medical profession. No system of health care will ever work unless the doctors of the nation make it work. So let us work together," he said, "for a system—a system that will continue to provide for choice, that will continue to provide for quality and one that will at the same time deal with the pressing problems of costs in an effective way that will not destroy quality."

The bulk of the president's 34-minute talk, which was punctuated several times by applause, was a challenge to America's physicians to assume leadership in curing and preventing drug abuse. That problem, he said, "is America's public enemy number one. It afflicts the rich and the poor, the blacks and the white, the servicemen and the civilians, and the ghettos and the suburbs. It spreads like a plague throughout our society. It erodes our nation's

strength. It destroys our nation's spirit. And worst of all, it undermines our nation's future.

"The best way to end drug abuse is to prevent it, and America's doctors are the indispensable front-line soldiers for success in this all-important battle. No one, believe me, no one can have more effect when he or she speaks out than a doctor on this issue of drug abuse. You speak with greater authority, because you speak about the power of drugs to save life—but also the power to destroy it.

"Rather than preach moralistically about the sinfulness of drugs, you can teach realistically about their physical and psychological impact."

The president finished this major portion of his speech by saying, "The AMA can once again render outstanding service at a point of critical need by helping to develop what I would like to call Project USA—a project which would marshal the tremendous energy, the brains, the dynamism, the leadership—the leadership—of the doctors of this country in an all-out battle against drug abuse."

After some remarks about the need for physicians to be more active in politics and community leadership, President Nixon closed with these words: "The health of America is in your hands, and by its health I speak not just of its physical health—but its mental health, its moral health, its character. Meet that challenge."

AMA Response

Directly and immediately accepting the president's challenge, the Board of Trustees came before the House with its Report EE, which the House adopted. The report points out that "In respect to the urgent problems of drug abuse, the Council on Mental Health and its Committee on Alcoholism and Drug Dependence have already given support to the President's announcement of the establishment of a Special Action Office of Drug Abuse Prevention within the Executive Office and to his proposal to strengthen resources and programs for treatment and rehabilitation of drug-dependent persons."

The report recommended and the House adopted as policy that the AMA "strengthen and expand its program to combat drug dependence with particular attention to prevention, identification, treatment, rehabilitation and research and that state and local medical societies be urged to give priority to the implementation of this program at the community level throughout the nation." The House also called upon "individual physicians—whether in practice, research, teaching or administration—to give special attention to problems of drug abuse and to volunteer their efforts to community programs."

Final Report to the House: Walter C. Bornemeier, President of the AMA

In describing his "Blueprint for the Future," Dr. Bornemeier pointed out that of three principal ingredients of medical care—cost, quality and availability—"availability is on the front burner. People are more concerned about getting medical care when they need it," he said, "than they are about its cost or its quality. The question never has been 'Is there a good doctor in the house?' or 'Is there a cheap doctor in the house?' The question has always been 'Is there a doctor in the house?' "

Along with increasing the number of physicians being produced by the nation's medical schools, Dr. Bornemeier said that "group practice appears to be the answer" to availability. "Groups can be either fee-for-service or have a prepaid package arrangement. They could be a combination of the two.

"When we eventually have a private practice group in every neighborhood," he said, "we will have come full circle, from a doctor over every drug store to a multispecialty group facility in every population center. It is my firm conviction that if we bring comprehensive medical care back into the population centers, the neighborhoods, and have medical care available 24 hours a day, seven days a week, the people will tell congress that the present system does not need to be restructured."

Dr. Bornemeier also pointed out that expanding group practice centers will lead to a strong come-back for the family physician, who will best be able to give complete care to the whole patient. "Group practice," the president said in closing his final report, "has been on the increase and all indices point to accelerated development of this type of practice. Along with this, a movement of group practice to the population centers is inevitable. Competition between groups will encourage distribution to residential areas. All of this adds up to availability, today's most important ingredient of health care."

Inaugural Address: Wesley W. Hall, President of the AMA

In his inaugural address, the AMA's 126th president began with a brief history of medicine as an art and science. "What was the state of medicine for some 6,000 years?" he asked. "Compassion, hope and the patient's confidence in the physician were the foundation stones upon which medicine rested for centuries. As an exact science, medicine had its beginning less than a century ago, when Robert Koch discovered the tuberculosis bacillus in 1882."

He traced the growth of medicine to the present time and then detailed some of the profession's more pressing problems of today, including the state of medical education, the need for more manpower, care for the poor, rural health, and the like. He pointed out, however, that often too much emphasis is put on problems and not enough on achievements. "We need not agonize that we have not done enough," he said. "We should trumpet our successes while we strive all the harder in those areas where we have not yet attained perfection. To assure that, in a rapidly changing world, the AMA will be able to pursue its historic goals," Dr. Hall offered suggestions for consideration by the House.

The first was that the Association have a constitutional convention to "streamline our governing process to suit the needs and pace of the 20th century physicians and its people;" to "combine overlapping functions within our organization;" and "enfranchise those whose voices we should hear."

He listed major changes made in past years by the AMA, but pointed out that "This year, one or two changes will not be enough."

Some of his suggestions were "at least one additional meeting day" for the House to conduct its business; re-examination of "the aims and duties of our 100-plus councils, committees and commisssions;" moving "through our state organizations to bring a greater number of young, able and productive physicians into our Association;" setting "a limit upon the number of terms delegates can serve in this House;" and rescinding "a number of outdated and long-ignored resolutions (that) remain on our books as policy statements.

Dr. Hall urged the Woman's Auxiliary to undertake new and increased activities in "encouraging prenatal care for the expectant mother, especially in rural areas and in areas where low-income families are concentrated;" and in "helping to combat problems of teenage drug abuse and addiction."

Referring to the fact that some physicians are critical of the AMA, Dr. Hall emphasized that "the goal of the AMA and the goal of these colleagues is the same: to provide the best possible health care for each and every American, at reasonable cost.

"I urge all physicians—those in practice, those in government, those in research and teaching, those in public health, those in administrative positions, those in all facets

of medical activity—to come under the AMA's umbrella, to bring to us their hopes, their beliefs, their ideas and their vigor."

In closing his inaugural address, President Hall said, "The basic needs of man are food, clothing, shelter, education and health. Certainly physicians have some expertise in each of these areas. We know the requisites of good nutrition; we are able to give advice concerning the health aspects of clothing and shelter; we can contribute to education; we care for the sick, and we attempt to keep the healthy in that enviable condition."

(The Board of Trustees brought before the House the question of a constitutional convention, as suggested by Dr. Hall. Delegates voted to defer action until the 1971 Clinical Convention, meanwhile requesting informational "white papers" on the subject from the Council on Constitution and Bylaws and the Council on Long Range Planning and Development.)

Changes in the Organization

The Guam Medical Society of Agana, Guam, was accepted as a constitutent association of the AMA, bringing to 55 the number of state, commonwealth and territorial associations.

The scientific Section on Psychiatry and Neurology was separated to form two sections—the Section on Psychiatry and the Section on Neurology.

The Bylaws of the Association were amended to create a new membership classification. Under "Active Members," there now are two classifications: Regular Members and Direct Members. There is no change in the definition of Regular Members. Direct Members include service members, physicians employed by federal agencies, and interns and residents.

Right of Access to Medical Care

The House elaborated its existing policy regarding the right of access to medical care by adopting this statement: "It is the right of every citizen to have access to adequate medical care, but it is the responsibility of the citizen or of society to seek it. The American Medical Association will use all means at its disposal in an endeavor to make adequate medical care available to meet the needs of each person.

"In the spirit of inheritance of the Oath of Hippocrates, the AMA reaffirms its obligation to humanity. In this effort, the AMA cannot assume the responsibilities of government or the individual citizen. The AMA also recognizes the right of the physician to choose whom he will serve and the conditions under which he will render this service. These are integral essentials in the delivery of quality medical care."

Drugs and Drug Abuse

In addition to the action taken in direct response to President Nixon's speech to the House, delegates also took several other actions on the subject of drugs and drug abuse.

A report of the Council on Mental Health and its Committee on Alcoholism and Drug Dependence was filed for the information of the Association. It contains these recommendations for the medical profession:

1. Increased attention to alcoholism and drug abuse in the curriculum of medical schools.
2. Medical students, interns and residents should be encouraged to associate themselves with "street clinics" to establish links between the profession and young drug abusers.
3. Continued development and dissemination of reliable information to physicians and other health professionals.
4. Laws and regulations should be modified to recognize alcoholism and drug dependence as illnesses.
5. Closer liaison between medical societies and law enforcement and licensure bodies to deal jointly with the problem of physicians suspected of professionally misusing or personally abusing drugs.
6. Continually up-dated factual material for public consumption.
7. Increased emphasis on the responsible use of drugs for therapeutic purposes, both by the public and by physicians.

The House resolved to follow "studies being conducted to ascertain the relationship between proprietary drug advertising in the mass media and excessive use of self-prescribed drugs and drug dependence problems" and to "cooperate in every way possible in the studies being conducted by the FTC to assure the enactment of proprietary drug advertising regulations in the interests of protecting consumers."

Delegates also resolved to "urge all physicians to limit their use of amphetamines and other stimulant drugs to specific, well-recognized medical indications."

In addition, the House resolved to go on record "favoring the implementation of stern measures for narcotic traffic control in Vietnam, as well as measures for the identification, prevention, diagnosis, and adequate treatment of addicts within the armed forces, with adequate provision for the availability of proper follow-up and aftercare."

Terminology and Definitions

Concerned with the growing use of the term "physician's associate" as opposed to the term "physician's assistant" to describe new health occupations, the Board and its Council on Health Manpower recommended (and the House agreed) that the term "physician's associate" be used only to denote another physician.

The House resolved that future editions of the publication AMA Drug Evaluations "avoid the use of the word 'irrational.'"

Delegates adopted three definitions in the area of peer review:

"Peer Review: Evaluation by practicing physicians of the quality and efficiency of services ordered or performed by other practicing physicians. Peer review is the all-inclusive term for medical review efforts. Medical practice analysis, inpatient hospital and extended care facility utilization review, medical audit, ambulatory care review, and claims review are all aspects of peer review.

"Medical Practice Analysis: A function of the medical society, or other organization authorized by the medical society, designed to coordinate all peer review efforts of a community. Medical practice analysis focuses on the development and application of criteria for optimal medical care, and evaluates the individual and collective quality, volume, and cost of medical care, wherever provided.

"Claims Review: Peer evaluation and adjudication of claims questions referred for peer review by any party with a valid interest in the case."

Definitions of other elements named in the "Peer Review" definition itself were referred back to the Council on Medical Service for further refinement.

Peer Review

Further in connection with peer review, the House resolved:

"That the American Medical Association and its constituent state associations reaffirm their support of voluntary mechanisms of review and education by physicians such as grievance committees, insurance review committees, and the numerous hospital review mechanisms, many of long standing;

"That the AMA and its constituent state associations continue to stress that peer review shall be considered a professional function and, as such, shall be carried out by physicians or under the sponsorship of the county and state medical societies;

"That this House of Delegates call on all state and county medical societies and the AMA to take an active responsible role in peer review and to document for the information of the public current functioning procedures and programs which are serving in the interests of delivering good medical care."

Better Health and Better Patient Care

With respect to teenage pregnancy, the House adopted the statements that "The teenage girl whose sexual behavior exposes her to possible conception have access to medical consultation and the most effective contraceptive advice and methods consistent with her physical and emotional needs" and "The physician so consulted should be free to prescribe or withhold contraceptive advice in accordance with his best medical judgment in the best interests of his patient." Earlier in that report, the House inserted the statement that "definite effort should be made to obtain consent from the minor's parents or legal guardian whenever possible."

Regarding maternal and infant care, the House adopted a report pointing out that "Application of recent advances in scientific knowledge and skills in the intensive care management of high-risk pregnant women and high-risk newborn infants will result in reduction of present maternal and infant mortality. A major contribution to such a program is the development of a centralized community (or regional) hospital-based newborn intensive care unit. Concentration of high-risk infant care programs in hospitals specially staffed and equipped to provide optimal care is a proven life-saving mechanism for infants at risk."

Concerned with the spread of venereal disease, the House resolved:

That medical societies be urged "to support education of patients and the public through more extensive and more imaginative use of all available media and through school curricula;" that the AMA "reiterates its support and cooperation with the National Commission on Venereal Disease in order to hasten the control of these diseases;" and that the AMA "strengthen in every way possible research efforts toward the development of vaccines for the active immunization of our population against venereal disease."

On health education in schools, the House resolved to encourage state and local medical societies "to establish active liaison with their school systems in order to provide lectures and appropriate educational support regarding: personal hygiene, the effects of tobacco and drugs, the problem of medical quackery and the role of physicians in maintaining good health."

To increase patient safety in hospitals, the House resolved that "medical staffs be urged to form a staff committee to cooperate with administration and lend guidance in developing safety programs that will include the concepts of prevention, detection, and correction, and which will fully utilize the expertise of physicians and other members of the health care team."

Considering the use of assistants in medical practice, delegates resolved that "the physician may properly delegate technical procedures to an allied health worker" but affirmed the principle "that whatever privileges may at any time be granted either to allied health workers or to independent limited practitioners, by law or otherwise, such grant in no way circumscribes the physician's authority in that field and in no way restricts the practice of medicine by the physician."

House Officers and Medical Students

The House commended "those county medical societies which have opened participation opportunities to House Officers" and recommended to county medical societies "that reduced membership dues be provided for House Staff members."

Delegates also resolved:

To request the Board of Directors of AMA-ERF "to investigate the feasibility of providing financial aid for the continuation and coordination of the SAMA-MECO Project." (Medical Education and Community Orientation.)

To "urge that the Congress support increased Federal aid to medical students."

"That residency training in community hospitals is worthy of strong and continued support."

To encourage "individual state societies to promote community programs in their states to provide facilities or loan programs for students for which the student agrees to return to the community after training."

That individual members of the AMA "assume sustaining membership in the Student American Medical Association."

And that the AMA "offer active support and counsel to the Student American Medical Association for their community health projects."

Additional Actions and Events

Delegates adopted a 39-page report on Physician Manpower and Medical Education, prepared jointly by the Council on Medical Education and the Council on Health Manpower, with help from the Council on Medical Service.

They approved a progress report of the Board Committee on Professional Liability and filed for information an 89-page summary of Computer Systems in Medicine.

They adopted a Judicial Council report reaffirming the position "that the basic principles of a fair and objective hearing should always be accorded to the physician whose professional conduct is being reviewed. These basic guarantees are: a specific charge, adequate notice of hearing, the opportunity to be present and to hear the evidence, and to present a defense. These principles apply when the hearing body is a medical society tribunal or a hospital committee."

They adopted the report of the Council on Long Range Planning and Development which included these objectives for the AMA:

1. To maintain an active, viable organization representing the majority of physicians of the United States.

2. To serve as the central coordinating organization of medicine.

3. To serve as the representative of the medical profession in its relations with other health professions, industry, government, labor, consumers and other nonmedical organizations.

4. To develop, stimulate and present scientific and professional programs and advances to the profession and public.

5. To continue its historic interest in all levels of medical education.

6. To assimilate recent medical graduates into the medical professional organizations.

7. To promote high standards of quality medical care.

Reports of Committees

Executive Committee

The Executive Committee, as usual, has met throughout the year to handle the housekeeping matters of the association and in many instances has referred matters that have come to their attention over to the Board of Trustees for their decision.

The minutes of the Executive Committee are published regularly in *The Journal* and copies of the minutes are available to the Reference Committee for their review. Therefore, this report will not be in detail as this information in detail is readily available.

The committee met following the close of the 1970 annual meeting, at which time Dr. Donald Kerr was elected chairman of the committee. New members coming on the committee were: Dr. Joseph Dukes, by virtue of being chairman of the Board, and Dr. Wilbert McIntosh, a member of the Board of Trustees.

Among some of the important activities of the committee was to request a meeting of the Executive Committee of the Indiana Regional Medical Plan to be held on December 16 for a discussion of the relationship between organized medicine and this group.

The committtee also referred to the Board of Trustees and to the Commission on Legislation the action of the 1970 House of Delegates approving the creation of a Medical Disciplinary Board.

The committee also noted the forthcoming meeting in November of 1971 of a White House Conference on Aging and submitted the names of Dr. Malcolm O. Scamahorn, President, and Dr. Peter R. Petrich, President-elect, to the Governor for his consideration in appointing them as delegates to this meeting.

The Executive Committee forwarded a request to the AMA Judicial Council for a ruling concerning the physician's participation in profit-oriented HMOs.

The committee was busy during the first quarter of the year going over matters which were before the General Assembly.

The committee noted that the State of Indiana ranked eleventh in AMA membership.

The committee held a meeting with the officers of the Indiana Osteopathic Association and arranged for a meeting between this group and the Board of Trustees as a means of discussing the opening of better communications between the two organizations.

The committee accepted and referred to the Board of Trustees the return of a $5,000 gift to Medi-Tech, which sum has been returned and deposited in the Indiana Medical Foundation.

The committee, after a discussion with the Indianapolis Power and Light Company, entered into a new type of contract for the furnishing of electrical power which is anticipated will save money on the operation during the coming year.

Inasmuch as the association has been in its present home since 1962 without any redecoration, the committee did authorize the repainting and the cleaning of the interior walls of the building.

Your committee also became a party to establishing an Indiana Perinatal Care Project, which is financed by a grant from the Board of Health.

The committee referred to the Board of Trustees many recommendations for appointment of members of the association to vacancies on AMA Councils and Committees.

The committee was conversant throughout the year with the proposal to make Marion County a testing center of an OEO and HUD program for delivery of medical care similar to an HMO program. This has been primarily a Marion County Medical Society matter but the Executive Committee has been kept informed as to developments.

This abbreviated rundown in no way attempts to cover the many matters which regularly come before your Executive Committee, but we sincerely hope that the membership has followed the actions of this committee as they have been reported in *The Journal* and we point out again that copies of all the minutes are in the hands of the Reference Committee.

In addition, there are reports on Medical Defense activities, *The Journal* and the Membership Report, as follows:

Medical Defense Activities

1. *Malpractice Cases.* A year ago, at the time of this report, August 1, 1970, the following three cases were pending before the committee:

Case 307—Suit filed March 22, 1962. Pending. (Expense to date, $1,042.73)

Case 309—Suit filed December 10, 1964. Closed February 1971. (Expense to date $450.00)

Case 313—Suit filed September 5, 1967. Pending.

Since August 1, 1970, and up to August 1, 1971, one new case has been filed.

2. *Medical Defense Fund Statement from August 1, 1970, to August 1, 1971:*

Bank Balance, August 1, 1970	$5,640.42
Receipts	3,433.75
Total Cash and Receipts August 1, 1971	$9,074.17
Disbursements:	898.82
Balance on hand August 1, 1971	$8,175.35

The Journal

A comparative report of *The Journal* operations over the past several years and the first six months of 1971 follows.

The first table shows the number of journal pages for the past six years (includes inserts).

This is a comparative report for the first six months of each year indicated.

Year	Reading	% Reading	Adv. Pages	% Adv. Pages	Total Pages	Av. No. Pages per Issue
1965	998	68	464	32	1462	122
1966	789	50	781	50	1570	131
1967	1041	58	751	42	1792	149
1968	1068	61	696	39	1764	147
1969	1041	67	509	33	1550	129
1970	1131	74	403	26	1534	128

The table below shows the total printing costs of *The Journal:*

Printing Costs

Year	Total Printing Cost	No. of Pages (Inserts Excluded)
1966	41,795.32	1410
1967	49,958.15	1450
1968	50,709.62	1463
1969	42,916.62	1312
1970	44,520.84	1346
1971 (6 months)	21,189.18	600

A comparison of advertising revenues for the first six months of the last four years, with a like figure for 1971, is as follows:

State	1967	1968	
Medical	23,468.96	24,153.24	
Journal Adv.	3,056.68	7,200.10	
Bureau	26,525.64	31,353.34	
	1969	1970	1971
Sold direct	17,086.59	15,791.12	13,138.30
by Journal	2,557.80	2,268.80	1,821.89
Totals	19,644.39	18,059.92	14,960.19

MEMBERSHIP REPORT

Total Members

	December, 1969	December, 1970	
ISMA	4,482	4,505	
AMA	4,330	4,337	
	July 31, 1970	July 31, 1971	
ISMA	4,456	4,489	+33
AMA	4,291	4,236	—55

DISTRICT REPORT AS OF JULY 31, 1971

↑ GAIN
— LOSS

DISTRICT	ISMA	AMA
1	+10	+ 5
2	+ 6	— 3
3	+ 3	— 3
4	+ 5	— 1
5	— 1	— 2
6	— 5	—10
7	+ 9	+ 4
8	— 7	—17
9	+ 4	— 1
10	+ 6	+ 1
11	+ 9	+ 2
12	—14	—29
13	+ 8	— 1
	+33	—55

TOTAL NEW MEMBERS

DISTRICT	AS OF JULY 31, 1971
1	9
2	7
3	7
4	8
5	4
6	4
7	24
8	3
9	11
11	11
12	6
13	20
	130

DEATHS

DECEMBER 1970	AS OF JULY 31, 1971
59	37

MEMBERSHIP REPORT

	Dec. 31, 1970 ISMA	July 31, 1970 ISMA	July 31, 1971 ISMA	July 31, 1971 AMA
1st District				
Gibson	12	12	11	11
Perry	8	8	7	7
Pike	3	3	2	2
Posey	7	7	6	6
Spencer	3	3	5	5
Vanderburgh	244	239	251	244
Warrick	7	7	7	7
TOTAL	284	279	289	282
2nd District				
Daviess-Martin	19	19	17	11
Greene	14	14	16	11
Knox	37	37	39	38
Owen-Monroe	83	83	88	78
Sullivan	13	13	12	11
TOTAL	166	166	172	149
3rd District				
Clark	47	47	47	41
Dubois	25	25	27	25
Floyd	44	44	45	42
Harrison-Crawford	9	9	9	9
Lawrence	27	27	28	24
Orange	8	8	7	7
Scott	6	6	5	5
Washington	7	7	8	8
TOTAL	173	173	176	161
4th District				
Bartholomew-Brown	55	55	56	48
Dearborn-Ohio	15	15	16	16
Decatur	11	11	13	11
Jackson-Jennings	23	23	21	21
Jefferson-Switzerland	30	28	29	26
Ripley	8	8	10	10
TOTAL	142	140	145	132
5th District				
Clay	13	13	13	13
Parke-Vermillion	17	17	17	17
Putnam	19	19	19	19
Vigo	119	119	118	116
TOTAL	168	168	167	165
6th District				
Fayette-Franklin	16	16	15	15
Hancock	26	26	27	27
Henry	39	39	38	35
Rush	12	12	13	13
Shelby	20	20	20	16
Wayne-Union	74	74	69	65
TOTAL	187	187	182	171
7th District				
Hendricks	22	20	23	19
Johnson	32	33	36	36
Marion	1072	1056	1057	1053
Morgan	19	19	21	19
TOTAL	1145	1128	1137	1127
8th District				
Delaware-Blackford	125	121	119	106
Jay	16	16	16	12
Madison	107	106	101	69
Randolph	17	17	17	14
TOTAL	265	260	253	201
9th District				
Benton	9	9	9	8
Boone	20	19	17	17
Clinton	14	14	14	14
Fountain-Warren	11	11	11	10
Hamilton	16	16	16	13
Montgomery	22	22	21	21
Newton	5	5	5	5
Tippecanoe	142	141	148	139
Tipton	11	11	11	11
White	7	7	7	6
TOTAL	257	255	259	244
10th District				
Jasper	8	7	8	8
Lake	464	453	447	413
Porter	51	51	62	60
TOTAL	523	511	517	481
11th District				
Carroll	7	7	8	8
Cass	36	36	38	33
Grant	72	71	76	75
Howard	65	65	70	70
Huntington	19	19	19	19
Miami	15	15	13	12
Wabash	33	33	31	24
TOTAL	247	246	255	241
12th District				
Adams	13	13	13	13
Allen	316	314	310	287
DeKalb	23	23	20	18
LaGrange	10	10	11	9
Noble	12	12	12	10
Steuben	11	11	10	10
Wells	46	46	39	39
Whitley	16	15	15	15
TOTAL	447	444	430	401
13th District				
Elkhart	114	114	111	102
Fulton	9	9	6	6
Kosciusko	13	13	14	14
LaPorte	96	94	97	86
Marshall	25	25	25	25
Pulaski	5	5	4	1
St. Joseph	232	232	242	240
Starke	7	7	8	7
TOTAL	501	499	507	481

SUMMARY

1st District	284	279	289	282
2nd District	166	166	172	149
3rd District	173	173	176	161
4th District	142	140	145	132
5th District	168	168	167	165
6th District	187	187	182	171
7th District	1145	1128	1137	1127
8th District	265	260	253	201
9th District	257	255	259	244
10th District	523	511	517	481
11th District	247	246	255	241
12th District	447	444	430	401
13th District	501	499	507	481
TOTAL	4,505	4,456	4,489	4,236

DONALD M. KERR, M.D.
Chairman
WILBERT McINTOSH, M.D.
MALCOLM O. SCAMAHORN, M.D.
PETER R. PETRICH, M.D.
JOSEPH DUKES, M.D.
LESTER H. HOYT, M.D.
HUGH K. THATCHER, JR., M.D.

Medical-Legal Review Committee

The Medical-Legal Review Committee met on May 12, 1971, and made recommendations for revision of the Medical-Legal Professional Code. Another meeting is set for September 8; after that meeting a report will be submitted to the House of Delegates.

JOSEPH G. S. WEBER, M.D.,
Chairman
WALTER ABLE, M.D.
RAYMOND L. NEWNUM, M.D.

Grievance Committee

According to the Purposes, Rules and Procedure of the Grievance Committee, the committee has met in 1971 on January 31, March 14, May 16 and July 11. Another meeting is scheduled for September 12.

As of August 1, 1971, 23 cases were considered during the year. Nineteen new cases were filed. All cases except eight have been closed.

The ISMA Grievance Committee continued to follow the procedure of past years. (1) Receipt of complaint is acknowledged by a letter which states that action can proceed only after receiving the complainant's permission to forward a full copy of the complaint to the physician or physicians named therein along with identification of those filing the complaint. (2) Should the requested permission be given, the physician named is asked to attempt a personal settlement of the complaint. (3) Should the physician be unsuccessful or should he request that his county medical society attempt settlement, the matter is so referred with the ISMA Grievance Committee retaining the responsibility as the rules governing it require. A greater attempt is being made at the local level to settle differences before the state committee is involved.

The members of the Grievance Committee have spent a great deal of time in revising the Purposes, Rules and Procedure of the Grievance Committee as mandated by the 1967 House of Delegates. The revision of the rules has been given to the board of trustees for their study and action.

The Grievance Committee wishes to thank the members of ISMA who have

been called upon to assist in discharging its responsibility. We have received excellent help.

WALLACE R. VANDENBOSCH, M.D., *Chairman*
JOHN M. PARIS, M.D., *Vice Chairman*
EUGENE S. RIFNER, M.D., *Secretary*
KENNETH L. OLSON, M.D.
WILLIAM D. PROVINCE, M.D.
RICHARD S. BLOOMER, M.D.
ROBERT G. YOUNG, M.D.
WILSON L. DALTON, M.D.
HUGH K. THATCHER, JR., M.D.
WILLIAM R. NOE, M.D.

Student Loan Committee

The Student Loan Committee has had one meeting during the past year, at which time a loan of $1,000 was granted. Two loans of $1,000 each were granted to two students who already have loans of $1,000 each. Only one new application was received.

Under the Guaranteed Loan Plan with the Indiana National Bank, which was instituted December 1, 1963, the Association has on deposit with the bank $20,810 to guarantee loans totaling $260,000. As of July 31, 1971, 108 loans, totaling $95,500 have been granted under this plan. Forty-one loans have been converted to installment loans in the amount of $42,965.29; eight loans totaling $7,700 have not been converted to installment loans; two loans of $1,000 each have been repaid in full.

A report on the Loan Fund which was under the Association management from October 1955, to December 31, 1963, follows:

Total loaned to 117 students	$58,458.36
Total repaid as of July 31, 1971	$58,356.60
Total amount outstanding, July 31, 1971	$ 101.76

Of the 117 who received loans,
116 have repaid in full
1 is making payments

Total due on above loan still outstanding	$ 101.76

The 1970 House of Delegates approved the report of the Reference Committee which asked the Board of Trustees to re-evaluate the Student Loan Program as the Reference Committee did not believe the loan fund was serving the purpose which the House of Delegates originally intended.

The Student Loan Fund does provide an essential service to students in need of financial help and it is the recommendation of the Student Loan Committee that this type of loan procedure should be continued.

HUGH K. THATCHER, JR., M.D., *Chairman*
JAMES O. RITCHEY, M.D., *Vice Chairman*
JOE DUKES, M.D., *Secretary*
MALCOLM O. SCAMAHORN, M.D.
LESTER H. HOYT, M.D.
GLENN W. IRWIN, M.D.
WILLIAM G. BANNON, M.D.

Sports and Medicine

The Committee on Sports and Medicine of the Indiana State Medical Association was expanded in 1970-71 to a total of 12 physicians interested and oriented to athletic medicine. The physicians were chosen to represent different regions of the state. Liaison was also established with the newly formed Football Coaches Association and the commissioner's office of the IHSAA, who would have ex-officio members on the committee.

The Committee on Sports and Medicine sponsored a Conference on Athletics and Medicine on November 12, 1970, at the Methodist Hospital in Indianapolis. Twenty-seven physicians in addition to sixty-six coaches, trainers and athletic directors attended the all-day program. This meeting was well received and will, hopefully, be continued yearly. The summary of the conference has already been forwarded to the ISMA office.

In the area of public and professional information, the committee sponsored a booth on athletic medicine at the ISMA state meeting in October 1970. The committee again will sponsor a booth and endeavor to improve on both the facilities and information to be provided in 1971.

Also, as a matter of public information, the committee made known through the news media the dangers of the heat intolerance in early football drills and outlined certain measures to prevent heat stroke. A warning of the dangers of rapid and excessive weight loss in wrestling was also made by the committee. These recommendations were published in newspapers throughout the state and received radio and TV coverage.

The committee also made a recommendation to the IHSAA of a rules change in football which would prohibit the "crack-back" block below the level of the hip by flankers or wide receivers. A questionnaire was sent to all coaches in the state regarding the suggestion and 80 percent of the coaches responding concurred with the committee's feelings.

The committee will continue to function to promote education in athletic medicine in both the professional and lay community. The committee will also serve to recommend any new medical safeguards in the field of athletics that it might deem necessary and serve as liaison to physicians, coaches, trainers, and all others interested in sports medicine throughout the state of Indiana.

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JAMES B. WRAY, M.D.
GILBERT M. WILHELMUS, M.D.
ARTHUR L. MOSER, M.D.
GARLAND D. ANDERSON, M.D.
THOMAS D. FOY, M.D.
LESLIE M. BODNER, M.D.
PAUL A. MACRI, M.D.

Medicine and Religion

No one likes to pass up a good thing if he knows about it. The good thing in this case is the help a patient can get by his doctor and his minister working together to aid him in his individual problems.

The Committee felt that while ministers and doctors do work together for the good of patients, many opportunities for such working together are overlooked. The reasons are many. Most doctors will concede that there is a need for doctors and ministers to work together for the good of the patient, but demands in other areas seem to crowd out the best intentions.

It was the opinion of the Committee that not only would the patient be benefited by the closer cooperation between minister and doctor in the care of these patients, but the doctor could obtain considerable help in solving a certain problem of a patient if the minister were to share part of the load. It is not uncommon for a doctor to struggle along with a difficult case when it is quite apparent that, in addition to the medical aspects of the case, there are overtones that would be best solved by skills that a minister has. In short, the complete treatment of such a patient is not a pill, but a program and a program involving the minister. This concept has not been readily "bought" by the medical profession.

The problem this Committee sought to solve was: "We have a good product (cooperative help), how do we sell it?" Taking a cue from the Cancer Society in their promotion of cervical cancer detection by the use of the "pap" smear, the patient first was sold on the necessity of having this "pap" smear. Then she went to the doctor and requested the "pap" smear whereupon the doctor provided the service. Using this same approach, we felt it would be possible to develop appropri-

ate public service announcements and other forms of publicity bringing out the advantage to the public of the team approach between minister and physician. Such announcements would have to be appropriate and in good taste. The Committee requests the board of trustees to consider this proposal and give approval or disapproval of this concept. Then details be worked out and submitted to the Board of Trustees for approval before any actual approach promotion is made.

We need to gather facts in two areas: (1) doctors who are interested in the field of Medicine and Religion in their communities, and (2) activities which are being carried out now which are in the field of Medicine and Religion.

The editor of the ISMA *Journal* has agreed to accept for publication an article publicizing the program in the field of Medicine and Religion. The committee will search for an author who can best write such an article. In addition, doctors in the state who are known to be interested in the field of Medicine and Religion will be contacted and requested to seek out others that they are aware of, who are interested in Medicine and Religion. Through this doctor-to-doctor contact, an ever-enlarging list of doctors over the state can be interested. It has been the experience over the country, as reported in national Medicine and Religion meetings, that the programs move only because individual doctors are interested in making the program move, and it is important to identify these individuals.

The problem of establishing hospital chaplaincies part-time, full-time, or on a trial basis was considered and it was felt the best approach would be to develop a letter to be sent to boards of trustees of the hospitals of the state, explaining chaplain service. Dr. Soper will author a letter for this purpose.

A third effort will be directed toward engaging seminary students to be more exposed to problems of the parishioner who is ill, so that the seminary student by the time he has graduated, will be more sophisticated in medical matters. In addition, it was felt that the medical student needs similar sophistication in matters of religion. It is felt that a great deal could be done to the good of the patients. Introducing more material into the curriculum, now crowded to the hilt, might be difficult but still possible.

George Washington University has a successful program in which seminary students and medical students meet at regular intervals in the evenings to discuss mutual problems. Several Indiana University Medical School students have been approached, and have indicated that this might be possible at Indiana University Medical School.

The last item considered was the provision of a Medicine and Religion booth at the Indiana State Medical Association meeting in October. The Committee requests of the Program Committee that space be allowed for such a booth. An effort will be made to have the booth manned by a doctor and a minister, as has been done in other state meetings.

BURTON E. KINTNER, M.D.,
Chairman
HUNTER SOPER, M.D.
EDWIN B. BAILEY, M.D.
JOHN C. SLAUGHTER, JR., M.D.

Supplemental Report of Medical-Legal Review Committee

Your Medical-Legal Review Committee recommends the adoption of a change in the existing Medical-Legal Professional Code by deletion of the phrase "entire testimony," appearing in Article III, Sec. 3, paragraph 3, and replacing it with the phrase "that portion of a transcript which fairly and accurately presents the issues in dispute."

We further recommend that the revised code be published in *The Journal* of the Indiana State Medical Association.

Reports of Commissions

Constitution and Bylaws

The Commission on Constitution and Bylaws had several matters referred to it by the Board of Trustees and previous actions of the House of Delegates and we make the following recommendations for changes in the Constitution and Bylaws.

Constitution

Constitutional change: This is being presented at this meeting for the first time and, as required in the Constitution and Bylaws, the proposed amendment shall lay over for one year for final action to be taken in the annual meeting in 1972.

Article V—In accordance with the recommendation of Past President Steen in his speech before the 1970 meeting of the House of Delegates, which the House approved and referred to us for proper language, we have prepared the following: Therefore, Be It Resolved, to amend Article V of the Constitution by adding an additional paragraph after the first paragraph to read as follows: "All sessions of the House of Delegates shall be open to all members in good standing of this Association for observation."

The Commission also had referred to it from President Steen's remarks the suggestion that the words "temporary absence" should be inserted in Section 7, Article IX of the Constitution. Your Commission feels that this is unnecessary as the provisions of this Article clearly set forth who shall serve in the absence of the president and believes the words "temporary absence" would be difficult to define and would serve no true function. Therefore, we recommend that no changes be made in Section 7, Article IX of the Constitution.

Bylaws

The following are recommendations for changes in the Bylaws and, if approved in this session, will become effective with the final vote on these recommendations.

Your Commission has received testimony with respect to the handicap placed upon Blue Shield by limiting the terms for elected M.D. members to their Board. It is the opinion of this Commission that the term of office of elected doctors to their Board of Directors is only a part of their problem. We are sympathetic to the request for unlimited terms of office. We are also convinced that this will not solve the problem or satisfy the individual members of the Indiana State Medical Association unless other recommendations are honored and implemented to assure the delegates that elected Board members are representing the membership of the ISMA.

We further recommend that the Indiana State Medical Association conduct seminars to prepare these elective or nominated members for their duties and that the trustees should make an annual report back to the constituent county medical societies of the record of their delegates.

We therefore make the following recommendation: "Therefore Be It Resolved that Chapter XXXII, Section 10 of the Bylaws shall be revised by deleting the last paragraph starting with the word "however" and, in lieu of the current last paragraph, a new paragraph to be numbered "b" be inserted to read as follows: "Any member selected or nominated to serve on the Board of Directors of Mutual Medical Insurance, Inc., (Blue Shield) may serve an unlimited number of three year terms as approved by his constituent county medical societies. The Board of Directors of Mutual Medical Insurance, Inc., (Blue Shield) should prepare a list of needed qualifications for nomination to this office."

Your Commission also had referred to it by the Board of Trustees the question of creating an office of Speaker and Vice Speaker of the House of Delegates. It is the considered opinion of this Commission that the office of Speaker would require knowledgeable acquaintance and opportunity of study of our problems before he could be effective. There would be danger of creating an unwanted and conflicting source of power.

Therefore, this Commission believes that the president's load could be lightened by prescribing definite duties to the president-elect. We believe this apprenticeship would tend to improve the efforts of both offices and preserve leadership of the Association to the office of its president. We therefore recommend that the offices of Speaker and Vice-Speaker not be created.

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WILLIAM J. MILLER, M.D.
GEORGE YOUNG, M.D.
EVRETT SMITH, M.D.
WILLIAM B. HUGH, M.D.
CHARLES B. HUGHES, M.D.
CHARLES PLANK, M.D.

Aging

The Commission met on January 31, 1971, April 18, 1971 and July 11, 1971, and discussed the resolutions that were submitted to the 1970 House of Delegates. It was felt that the members of the Commission had adequately represented and supported these resolutions in the Reference Committee, but that the Reference Committee had closed minds with the viewpoint that this would open up administrative difficulty, in that partial disability would be difficult to administer. We do not feel that it is the province of the Indiana State Medical Association to judge whether the administrative problems are difficult, merely to judge the principle of partial disability, and allow the legislators to write appropriate administrative policies. It was our opinion that this had been handled quite well in the Social Security Department; but that the Veterans Administration had not handled partial disability well. There is, therefore, precedent for managing the partial disability through the Social Security.

It was moved that this resolution should be resubmitted. It had also been requested that we submit a report of the statement of policy, and a copy is attached.

The Commission, through its chairman, participated in meetings to work out policies to be submitted to the state meeting on aging in Bloomington, and to be further presented to the President's Commission on Aging in Washington, D.C. in the fall.

It was the Commission's general opinion that the Presidential Commissions are probably worthwhile, they do present opportunities to think through the various aspects of Aging; however, the major emphasis would come from Washington rather than from the grass roots.

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DANIEL RAMKER, M.D.
THOMAS A. ELLIOTT, M.D.
DANIEL BERNOSKE, M.D.
HAROLD E. RENDEL, M.D.

Statement of Policy of the Indiana State Medical Association, as presented by the Chairman of Commission on Aging at the State Meeting for Aging in Bloomington, May 15, 1971.

It is the Policy of the Indiana State Medcial Association as a professional organization of medical doctors:

1. To deliver medical care to the aged. This would include, but is not limited

to, early recognition of disease, treatment of disease and the application of preventive practices to preserve health.
2. To recommend, counsel and advise in the construction of facilities to expedite the efficient and economical delivery of the above health care.
3. To consult and advise on the education of the public regarding health care and delivery of health services so that the public is made aware of the importance of all of the current scientific knowledge that would be applicable to their personal and community health.
4. To make every possible effort to see that every citizen has health facilities available and, wherever possible, that the choice of physicians be entirely at the discretion of the patient, and that the physicians have a free choice of the method of treatment. That free choice of the facilities and none of the patients or physicians be denied the use of full range of medical treatment that is available.
5. That the physician's dedication to the preservation of life be to the preservation of the complete socio-psychological as well as physiological life.

Medical Economics and Insurance

The Commission on Medical Economics and Insurance has met five times during the past year. We submit the following report:

1. Insurance Programs
   A. *Indiana State Medical Association Disability Program.* This program has been a very stable program after five years of experience. There is now available a maximum benefit of $1,500 per month. Because of favorable underwriting experience, the benefits have been increased 10% for the current year. This increase is subject to a yearly review depending upon the underwriting experience. The renewals for this program are nearly 100%. A business overhead program is expected to be offered this fall. This will be tax-deductible, a 15 or 30-day waiting period, with death benefits payable to the estate of the insured.
   B. *Indiana State Medical Association Group Life Insurance.* This program has been accepted by a much larger number than was considered likely at the outset of the program. The Valley Forge Life Insurance Company has been very pleased with the response. Over $5,000,000 of insurance is now in force. As of this fall, the maximum amount of insurance available to Indiana State Medical Association members in this group program will be increased to $40,000 before the age of 60, and the commission privilege is retained.
   C. *Indiana State Medical Association Group Automobile Insurance.* This type of insurance is currently being studied. The Commission has received approval from the Board of Trustees to proceed with a feasibility survey of the Indiana State Medical Association membership if an acceptable policy is received. It is anticipated that this survey may occur during the late months of 1971.
   D. *Medical Liability Coverage.* The Commission has been unable to obtain firm commitment from any insurer even though CNA is currently engaged in negotiation with the AMA regarding this matter. CNA was unwilling to participate with the Indiana State Medical Association in a program because of the lack of interest on the part of Indiana State Medical Association members when surveyed last year to participate in such a program. The Commission is monitoring this field closely and has met on two occasions with representatives of other insurance companies. Additional information is to be studied. A tentative proposal has recently been received from one major company and a second major company has expressed an interest in discussing coverage of Indiana State Medical Association members. If additional information or definite proposals are received, a supplementary report will be presented to the House of Delegates.

II. *Matters Referred to the Commission by the Board of Trustees and by the House of Delegates.*
   A. *Resolution 69-27.* A review of Blue Shield-Blue Cross benefits. The Commission held that it would be impossible to review each of the nearly 400 programs offered by Blue Cross-Blue Shield. The Commission would point out that most programs are negotiated between management and a union with dollar amounts stipulated and that the coverage is based on the available plans which, in turn, are based on the negotiated dollar amount. The Commission would make the following recommendations:
      1. Each health insurance company should provide each policyholder with a summary of benefits available under the policy in easily understood language.
      2. Encourage Blue Shield and Blue Cross to increase coverage whenever and wherever possible, particularly in the realm of outpatient and diagnostic coverage.
      3. Provide better communication with physicians and with policyholders regarding the policies that are held, in order that all will have a more realistic understanding of the health care financing mechanism and the limitations of many policies.
   B. *Resolution 70-3.* A study of the development of relative value schedules indicates that they have become "a way of life" for many specialty groups and many county societies. The Commission recommends that relative value schedules be considered a matter of local option, by county medical societies or the Indiana State Medical Association. The Commission wishes to point out that relative value schedules, peer review, medical foundations, and HMOs cannot provide all the answers to health and to health care financing. There is a fear among the members of the Commission that these programs can lead to much misunderstanding. It is the intention of the Commission to follow closely the plans for HMOs in their relationships with insurers, particularly the Blue Cross and Blue Shield program.
   C. *Resolution 70-4.* Fee-negotiating mechanisms. There appears to be little or no functional fee-negotiating mechanism existing at the present time, except perhaps the relative value schedules in association with the foundations or programs similar to Champus. No satisfactory method has been uncovered by the Commission regarding a satisfactory fee-negotiating mechanism. At the 1971 annual meeting of the AMA in Atlantic City, the House of Dele-

gates adopted the following report of the AMA Board of Trustees: "It would be inappropriate at this time to seek such new mechanisms to provide for the negotiation for professional fees or to deal with the subject of how physicians render their services."

We might suggest that the only real fee-negotiating mechanism is a union or a guild.

D. *Medical Foundations.* Regarding medical foundations, the Commission believes that medical foundations include many facets:
1. Medical care; 2. Prepayment; 3. Peer review.

These are only a few of the factors relating to medical foundations. It is the belief of the Commission that, since peer review is a very important part of the foundation concept, basically a decision must be made by the Board of Trustees or by the House of Delegates on the applicability of county-wide or state-wide peer review in relationship to the county societies or Indiana State Medical Association. The society must consider whether an Indiana State Medical Association foundation would merely provide or perform claims review and utilization review, or whether it should merely participate in review, or participate in actual medical care procedures. It is the opinion of the commission that the latter concept would be impractical.

E. *Parameters, Medicaid and Medicare Services.* The commission approved the following statement to be sent to the Board of Trustees: "The commission has considered the parameters for Medicaid and Medicare services as presented to the Board of Trustees by Blue Shield." It found the parameters to be completely unacceptable. The Commission recommended to the Board of Trustees that they inform Blue Shield that these parameters are entirely unacceptable to the Indiana State Medical Association and to its members. If Blue Shield has evidence of irregular medical practice, it should present such information to the proper medical authorities and not presume there are irregular practices. Such parameters are restrictive rather than conducive to good medical care. It would appear now that dollars have become the primary consideration for the care of the Medicaid and Medicare recipients rather than the promised good medical care.

F. *Payment to assistant surgeons.* The Commission on Medical Economics and Insurance has considered the matter regarding payment to be made to assistant surgeons. The following is our recommendation:

> In accordance with previously established Indiana State Medical Association policies we believe the assistant surgeon, should be compensated for his service, regardless of whether an intern or resident might be available as an assistant. Payment should *not be* made to an intern or resident for providing assistance in surgery.

The Commission has recommended that a pamphlet entitled "Health Insurance—Which Plan for You?" published by the AMA is an excellent reference for those interested in the subject. The Commission has recommended that this brochure be made available to the members of the Association and to their patients. The Commission further recommends that all members carefully read the article on medical care foundations that appeared in the Indiana State Medical Association Journal in January 1971.

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Medical Education and Licensure

The Commission met on January 31, 1971, April 18, 1971, June 6, 1971 and September 12, 1971. In addition to the regular Commission members in attendance, Dr. Steven Beering, Dr. Raymond Murray and Mr. Peter Foster (SAMA representative) attended as guests and consultants.

Materials, subjects for study and resolutions assigned to this Commission were: (1) Resolutions 70-20, 70-28, 70-32. (2) Ivy Tech matters. (3) SAMA MECO project.

Other subjects and problems considered by the Commission were: (1) Physicians' Assistants, (2) Continuing Medical Education, (3) Student-Faculty-ISMA Retreat, (4) Preceptor Program, (5) Proposed Medical Practice Act, (6) Indiana University School of Medicine, (7) Foreign Medical Graduates.

Action taken on materials, subjects and resolutions are as follows:

1. a) Resolution 70-20 was referred to the Ad Hoc Committee for Physicians' Assistants with a recommendation for registration rather than licensure for Physicians' Assistants.

   b) Resolution 70-28 was considered. A motion was made and passed that the Commission feels that it has adequate representation and adequate liaison with the Governor's Commission and the Indiana University School of Medicine and would continue to keep the Board of Trustees informed. This resolution was endorsed by the Commission.

   c) Resolution 70-32. The Commission felt that since the matter of Foreign Medical Graduates had been adequately discussed and acted upon by the Board of Trustees of the ISMA, no further action by this Commission was necessary.

2. Ivy Tech matters related to curriculum changes in the nurses training program—for example, the ORT program curriculum. It was felt that since this was an internal matter it would be a mistake for the Commission to take a stand. No action was recommended by the Commission.

3. The MECO project of SAMA.

The Commission had previously approved the principle of the MECO project.

A report by a SAMA representative was given and discussed by the Commission.

The action and recommendations on other subjects and problems considered by the Commission are as follows:

(1) Physicians' Assistants—At the January 31 meeting there was much discussion and study of the problem. The results of the survey of the specialty sections of ISMA made at the last annual meeting were circulated.

Since the ISMA Board of Trustees had formed an Ad Hoc Committee on Physicians' Assistants, no further action was taken and this Commission moved to re-

fer all information and matters regarding Physicians' Assistants to the Ad Hoc Committee.

(2) Continuing Medical Education—A subcommittee of the Commission was formed to study and make recommendations to the Commission on continuing medical education as a requirement for ISMA membership. This subcommittee presented recommendations for adoption by the Commission. These recommendations were amended according to request by the Commission and are as follows:

1. That the Commission on Medical Education and Licensure establish a statewide mechanism for accrediting non-university programs following the guidelines of the physicians' recognition award.
2. That all such programs be annually re-evaluated and published for the information of the membership.
3. That the Indiana University School of Medicine be commended for the quality and quantity of programs offered and that the school be encouraged to continue its excellent cooperation and that it attempt to offer as many programs as possible outside the Indianapolis area.
4. That adjacent areas in establishing programs strive to coordinate their efforts to avoid reduplication.
5. That the Commission should continuously assure itself that the programs being offered are tailored to meet the needs of the physicians.
6. That when the above have been accomplished, the House of Delegates of the Indiana State Medical Association be requested to make mandatory participation in the continuing medical education program to fulfill the requirements of the physicians' recognition award.
7. That the accreditation program should be completed by January of 1972, allowing action by the House of Delegates in the fall of 1972.
8. That retention of membership in the Indiana State Medical Association will necessitate successful fulfillment of the 150 hours of continuing medical education, as outlined by the physicians' recognition award, or as may be modified by the House of Delegates of the Indiana State Medical Association.
9. That all of the above be implemented based on the conviction that a program of continuing medical education will result in improved quality of patient care.

The Commission accepted these recommendations with the request that the subcommittee prepare them in the form of a resolution to be presented at the annual meeting in October.

(3) Student-Faculty-ISMA Retreat—The report of last year's retreat was studied and recommendations for the next retreat were made. The Commission has offered its help in planning the next retreat.

(4) Preceptor Program—Closer liaison is being maintained between the Commission and the Indiana University School of Medicine with Dr. Egger of the Commission and Dr. Alan Fischer, chairman of the new program, Family Medicine, at Indiana University School of Medicine. Some recommendations have been made and are under consideration to strengthen the program and make it more relevant. A preceptor training seminar is being considered. This will be a joint effort by the ISMA Commission and the I.U. School of Medicine.

A certificate of recognition to be presented by the University to the Preceptors was presented to the Commission by Dr. Beering.

(5) Proposed Medical Practice Act—This was presented to the Commission by Dr. Merritt Alcorn, president of the State Board of Registration and Examination, and discussed. The Commission is studying this proposed Act which will be modified and presented to the legislature after careful preparation.

The Commission recommended it sponsor meetings over the state, probably in four areas, to inform the state physicians regarding the Act and ask their guidance in the final presentation.

(6) Legislation on Foreign Medical Graduates—House Bill 1260 was studied by the Commission. The interpretation of the State Board of Registration and Examination was presented by Dr. Alcorn. The Commission is concerned about the new law, particularly the two-year temporary licensure under a sponsor or preceptor.

(7) I.U. School of Medicine—Throughout the year, extremely close liaison has existed between the Commission and the I.U. School of Medicine. Always attending the meetings, either as a member or guest, were representatives from the Dean's office. They reported on the status of the school, the admissions and the admission procedures and the 7-Center plan. They have cooperated in every way with ISMA and contributed much to the work of the Commission.

The Commission wishes to thank the ISMA staff for its help in the work of the Commission. I wish to thank also each of the members of the Commission, as well as the guests who have attended to help in the business of the Commission.

FRANKLIN A. BRYAN, M.D., *Chairman*
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DANIEL H. CANNON, M.D.
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GILBERT J. HIMEBAUGH, M.D.
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BETTY DUKES, M.D.

Public Health

The Indiana State Medical Association Commission on Public Health held four meetings this last year and acted on a large number of issues, as follows:

Resolution 70-15 *on physician exams for school employees*: It was decided that the intent of the law was tuberculosis control and not physical examinations, so the Commission recommended the same action as it took one year ago—namely, that the word "physical" be eliminated from line 10 of House Enrolled Act 1290, and the Board of Trustees was so notified.

House Bill 1176: This law provided for county council and commissioner control over salaries in the Department of Health. The Commission decided that this was an unwise provision and informed the Commission on Legislation of our strong disapproval. As passed later by the legislature, this gives the commissioners budgetary control over only non-medical personnel of the Health Department.

Resolution 70-27: To develop a program under the auspices of Indiana State Medical Association to obtain information and formulate recommendations on drugs and euphoriant agents for the guidance of our members and to transmit these results to the membership and provide the public with recommendations: The Commission felt that authoritative information was already available on this subject. It obtained a huge bibliography from the State Board of Health. A letter was composed to this effect and will appear along with all articles probably in the August *Journal* of the Indiana State Medical Association. The above resolutions were the main

ones referred to the Commission but many others were also handled. Subjects included glass storm doors, environmental control, public health departments, mobile homes, immunization of school children, regulation of hearing-aid dealers.

Eagle Creek Watershed Feedlot: We wholeheartedly supported the position of the Indiana Academy of Pediatrics to the effect that animal feedlots should not be located in present or future watersheds of reservoirs for recreational or municipal water supply, and we recommended this to the Board of Trustees.

The Commission spent some time on *the subject of V.D.* We received a letter suggesting our Commission recommend semi-annual serological tests for syphilis on college students, or at least a pilot program doing this. We decided that V.D. was receiving adequate publicity and its recognition would best be continued by alerted doctors in general, especially college doctors. Another letter came to the Commission concerning V.D. from La-Porte County wanting help from Indiana State Medical Association in a school education program. The magnitude of this V.D. problem is such that the subject should be on the agenda of the Commission next year.

Program for the Indiana State Medical Association annual meeting: Continuing the effort of the Commission on Public Health of one year ago, discussion was held on having a program on pollution at the fall meeting. Phone calls were made to the program committee and a letter written suggesting resource persons for this subject.

Safety Glasses: The Commission recommended by a letter to the State Ophthalmological Society that legislation be introduced to the State Legislature to require safety glasses for all spectacles.

Full-time Health Departments: Feeling that many of the problems of public health would be better solved by full-time health departments covering the whole state, the Commission invited Dr. A. C. Offutt, State Health Commissioner to come to our meeting as a resource person on this subject. He suggested by consolidating the present 101 departments into a significantly smaller number thus broadening the tax base, there would be enough money to support a good local health department for all areas. In this way activities which now are being poorly and partially done by volunteer persons would receive the attention their importance deserves.

Many problems can be seen when such a program is considered. But the Commission received the proposals with general approval. This subject should be investigated further and helped in its planning by organized medicine.

Pollution: The subject of solid-waste disposal and air and water pollution were discussed at length, also with Dr. A.C. Offutt, State Health Commissioner. The problems of pollution must be kept in realistic perspective in order for society to solve them. With all the groups who are interested in pollution, doctors are and should be the key and most influential. Organized medicine should be active in composing legislation in this field.

Finally, it is suggested that at least four subjects should be on the agenda of the Commission on Public Health for next year:

(1) Activity in occupational health. This subject was not covered this last year. Among many subjects which could be covered are employment of handicapped, noise standards, alcoholism in industry, and free choice of physicians in industrial injuries.

(2) Continuing interest in and support of the anti-pollution program and active participation and legislation on the subject.

(3) Venereal disease control.

(4) Improvement of local health departments in the state.

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WYANT J. SHIVELY, M.D.
WILLIAM SIGMUND, M.D.
WILLIAM C. VON DER LIETH, M.D.
LOWELL J. HILLIS, M.D.

Public Information

The Public Information Commission met on two occasions this year to consider routine and new business. The highlights of these meetings and the Commission's recommendations are as follows:

DRUG LITERATURE: Literature and information on this timely subject are available from the AMA. This fact was brought to the attention of the local county societies by the Commission, and this literature is recommended as a very valuable source of information.

TODAY'S HEALTH GUIDE: This AMA book is felt by the Commission to be quite well written for lay readers. It is felt that it is excellent medical reference material. It has been recommended to the local county medical societies that they might well spend the money to stock school and public libraries with this book and so make a good public relations gesture locally.

WAITING ROOM DISPLAY KITS: The Commission has initiated this new program but, as of this writing, the final, complete program has not been formally presented to the Board of Trustees nor has any funding for this program been given. It is hoped that by the end of the present year, or the beginning of 1972 at the latest, the Board of Trustees will have had this program for their consideration. The Commission feels that a continuing service to all ISMA physicians might well be periodic distribution of placards, suitable for display in the physician's waiting room and containing subject material explaining organized medicine's views on medical, social, and economic problems.

PHYSICIAN LIABILITY BOOKLET: A booklet concerning the liability of the physician was considered by the Commission for distribution to every ISMA physician. The Commission feels that if the cost estimates are favorable, this booklet should be distributed to every physician currently in the state and to every new member of ISMA thereafter.

1971 JOURNALISM AWARDS AND PHYSICIAN'S COMMUNITY SERVICE AWARD: Nominees and applications for these awards were screened by the Commission and selections for each category were made by the Commission. The Commission was gratified by the excellent response of the many people who submitted material for consideration for these awards. The material submitted was excellent in all cases. The increase in the number of nominees and applicants over last year was felt to be due in great measure to the added help given by each member of the Board of Trustees in distributing the information about these awards in their individual districts. The Commission also felt that distribution of news of previous winners to the various media helped in gaining more applicants. The Commission recommends to future Commissions that this method of application distribution be followed in subsequent years.

ISMA FILES ON PHYSICIAN'S ACTIVITIES: The Commission feels that these files should be updated, especially as to the physician's extra-curricular, public service activites. The Commission feels that they should author a questionnaire to be mailed to each ISMA active member. The Commission recommends

that this project be undertaken as a new project for a future Commission.

The Commission would like to thank all of those Commission members who actively worked on the Commission this year. The Commission would also like to personally thank Mr. Ken Bush for all of his services to the Commission during the past year.

FRED W. DAHLING, M.D.
Chairman
WILLIAM B. CHALLMAN, M.D.
THOMAS O. MIDDLETON, M.D.
LOUIS H. BLESSINGER, M.D.
KENNETH D. SCHNEIDER, M.D.
RICHARD S. BLOOMER, M.D.
ROBERT W. HARGER, M.D.
PAUL BURNS, M.D.
SEYMOUR W. SHAPIRO, M.D.
REEVE PEARE, M.D.
BARBARA BACKER, M.D.
HARRY G. BECKER, M.D.
VICTOR JOHNSON, M.D.

Special Activities

During the 1970-71 year the Commission on Special Activities concerned itself with some old and some new problems. The matter of the orientation program for new members was further discussed. The prevailing apathy of physicians with regard to the role and functions of the Association and, especially, the apparent lack of interest in active participation in the affairs of the Association, present serious obstacles to the introduction of an effective orientation program. An alternative possibility to presenting an orientation program at the local level was suggested and explored. It consists in presenting an orientation program to medical students through the facilities of the Indiana University School of Medicine to which Dean Irwin responded favorably. Details are being worked out.

The Commission also devoted much time to the issues of drug abuse and alcoholism. This subject was discussed in one of the Commission's meetings with Dr. William Murray, State Commissioner of Mental Health. The Commission passed a recommendation that ISMA "lend full support to efforts to study drug abuse and drug abuse education, help determine needs, develop programs with the State Board of Health and the Department of Mental Health, and make recommendations to the next session of the Indiana General Assembly."

Finally, the Commission concerned itself with the question of the doctor shortage in rural areas. Mr. Philip Willkie, president of Southern Indiana, Inc., reported on his ideas. The matter is to be discussed further.

HANUS J. GROSZ, M.D., *Chairman*
MARVIN F. PRIDDY, M.D.
CHARLES L. MILLER, M.D.
WILLIAM H. GARNER, JR., M.D.
JOHN C. LINSON, M.D.
FRED E. HAGGERTY, M.D.
ADOLPH WALKER, M.D.
FRED POEHLER, M.D.
EVERETT DONNELLY, M.D.
PETER E. GUTIERREZ, M.D.
ROBERT P. ACHER, M.D.

Voluntary Health Agencies

The members of the Commission appointed by the President for this year are as follows:

NORMAN R. BOOHER, M.D., *Chairman*
LOWELL W. PAINTER, M.D., *Vice-Chairman*
ROBERT H. RANG, M.D., *Secretary*
ALBERT RITZ, M.D.
T. A. NEATHAMER, M.D.
HARRY R. BAXTER, M.D.
WILLIAM G. BANNON, M.D.
WAYNE ENDICOTT, M.D.
HAROLD L. MILLER, M.D.
WALFRED A. NELSON, M.D.
LLOYD L. HILL, M.D.
RICHARD WILLARD, M.D.
FRANK J. McGUE, M.D.
MAX HOFFMAN, M.D.
CHARLES RUSHMORE, M.D.

The chairman attended the organizational meeting held by the president in November for all Commission chairmen, and the first meeting of the Commission on Voluntary Health Agencies was held on the 23rd of January, 1971.

Because of the illness of Doctor Norman R. Booher, the appointed Chairman, Doctor Scamahorn temporarily presided at this meeting, and the members of the Commission elected Doctor Lowell Painter Vice-Chairman, and Doctor Rang was elected Secretary-Treasurer.

The annual report for 1970 was reviewed and the action of the House of Delegates on this report was presented.

A review of the effect of the distribution of the annual placard (reproduced in miniature by the Indiana Tuberculosis Association) was reviewed and enthusiastic responses were noted from the governor, the mayor of Indianapolis, the State Board of Health, and the Indiana Manufacturers' Association. It was noted with especial enthusiasm that the Manufacturers' Association had asked for more than two thousand placards to be distributed to their member industries.

The Commission agreed to sponsor a scientific program for the fourth straight year before the annual meeting of the Indiana Public Health Association in April.

A dinner for the members of the Commission present, and their wives, was held at Kendall Inn, Saturday night, January 23.

On Sunday morning, January 24, the Commission reconvened and met with the presidents and executives of all the voluntary health agencies with statewide programs in the State of Indiana at the headquarters building of the Indiana State Medical Association. The programs of every voluntary agency were reviewed by requiring each representative to speak. Some suggestions from these agencies were received, but the bulk of the comment was very complimentary to the work of the State Medical Association through this Commission. The comment was again repeated that it is very difficult for the voluntary agencies to get physicians to their meetings and to be active in their Board of Directors. This has been a derogatory comment on the part of these organizations as far as the ISMA is concerned for many years.

Dr. Byron L. Steger, chairman of program committee, was present, and with him plans were completed for the State Medical Association and the voluntary agencies to present a scientific program at the annual meeting of Public Health Association in Indianapolis on Thursday, April 22, 1971. As a gesture of goodwill, all the guests were invited to a buffet luncheon with the Indiana State Medical Association as host at noon.

The second and final meeting of the Commission was held on April 22. This day was begun with a breakfast, hosted by ISMA, at which the executives of voluntary agencies and the speakers were guests. A very spirited and helpful discussion ensued at this breakfast.

A scientific program was presented before the meeting of the Indiana Public Health Association, with Dr. Peter Petrich, president-elect of the Indiana State Medical Association; Dr. Eli Goodman, member of the Board of Trustees of the Indiana State Medical Association, and Dr. Thomas A. Neathamer, member of the Commission on Voluntary Health Agencies, as speakers. This program was an excellent one and was very well received by the audience.

After the scientific program, the Commission held a luncheon meeting at the Stouffer Inn and the critique of the program just presented was undertaken, with certain suggestions to improve it in a sub-

sequent year, if this program is to be continued. It is felt that next year's program should be a followup on the subjects of the speakers addresses this year, especially on physicians' assistants programs in Indiana and the well-baby clinic in Jeffersonville.

The work of the Commission during the year was reviewed in detail and the Commission authorized the distribution of the placards, listing the approved voluntary health agencies in the State for another year as of May 1st. The distribution of these placards was to follow a pattern similar to last year, with 2300 copies going to the Indiana Manufacturers Association and a wide distribution by the voluntary agencies themselves, plus distribution to all doctors of the state through the field secretaries. The news media and others are to be contacted as last year.

The members of the Commission voted unanimously to repeat the January meeting with the representatives of the agencies in January 1972, with the direction that the chairman request from the Board of Trustees of the Indiana State Medical Association that the general meeting on Sunday morning be expanded to not only the executive secretaries and presidents of the various voluntary health agencies but to ten lay volunteers from each of these agencies. This would entail the same type of agenda as presented in the past with a general discussion of all the programs of the voluntary agencies and those concerned with them in the ISMA, with the ten volunteers present to hear the discussion. This would entail furnishing some type of luncheon to this many additional individuals. It was also decided by the Commission that the Commission hold a business meeting on Saturday, preceding the Sunday meeting, beginning at 4:00 p.m. Wives of the Commission members would be extended an invitation to join them at 6:30 p.m. for dinner. A letter requesting an additional $500 over and above the usual budget has been directed to the chairman of the Board of Trustees and the Executive Committee.

The agencies approved by your Commission this year, under the same criteria as previously established, include:

American Cancer Society, Indiana Division
Indiana Society for the Prevention of Blindness
Indiana Society for Crippled Children and Adults, Inc.
Indiana Heart Association
The Arthritis Foundation
Mental Health Association in Indiana
Indiana Tuberculosis and Respiratory Disease Association
United Cerebral Palsy of Indiana
Indiana Chapter, National Multiple Sclerosis Society
Tri-State Epilepsy Association, Inc.

The Chairman would like to acknowledge his appreciation of the continued cooperation of the members of the Commission and especially would like to thank Dr. Lowell Painter who stepped into the leadership of the Commission during the illness of the chairman, and to Mr. Kenneth Bush who has remained a very stalwart helper in all of the activities of this Commission.

NORMAN R. BOOHER, M.D.
Chairman

Emergency Medical Services

The Commission has held two meetings and is planning another meeting following a report of the results of a survey on emergency room equipment in all Indiana hospitals, and the staffing of these hospitals. The survey was mailed to all hospital chiefs of staff and hospital administrators, and copies sent to all county medical societies for their information on June 9, 1971.

It is planned that the results of the survey will be returned to all societies and hospitals, so that each hospital in Indiana will have an opportunity to compare itself to other hospitals of similar size. If these results are available by the time of the annual convention, they will be included as an addendum report to this report.

The Commission notes that in data collected by the Indiana Hospital Association and the Indiana State Board of Health, such information is not available. Results will also be made available to the Governor's Advisory Committee on Emergency Medical Services.

Following are some of the points discussed at the meeting of April 7 which the Commission feels should be reported to the House of Delegates:

(1) The Indiana Emergency Medical Service Plan, as formulated by the Governor's Advisory Committee, is now five years old.
(2) Concerning hospital statistics, Robert L. Rogers, Director of the Hospital and Institutional Services Division, Indiana State Board of Health, has as complete information as anyone in Indiana.
(3) The Commission on Emergency Medical Services of Indiana State Medical Association could avail itself of this data and interpret the material to the county societies.
(4) A study, known as the Hoffman Report, is now being completed at Marion County General Hospital on emergency medical care and the results of this study will be made available to the Commission.
(5) Many organizations proceeding in different directions, seeking solutions to emergency medical service problems, are being brought into closer cooperation through the National Research Council.
(6) The American Medical Association accepted in March an emergency medical service plan which is almost identical to the Indiana plan.
(7) The Commission was urged to direct its efforts in achieving the goals of the Indiana Emergency Medical Services plan. These are listed as "Recommendations for the Emergency Medical Services Program," pages 4-8 in the Plan.
(8) Training courses for ambulance attendants and ambulance institutes were conducted by the Indiana State Board of Health in various locations throughout Indiana.
(9) Emergency Medical Service plans should not only be developed by counties but should extend through the medical society districts.

H.B. 1753, introduced in 1971 in the General Assembly, was followed closely by the Commission. The proposed law was designed to accomplish the following: 1) adopt the uniform ordinance of the National Academy of Science governing licensure and operation of ambulance service; 2) establish an essential equipment list for ambulances; 3) set forth training programs for ambulance personnel; 4) extend Good Samaritan Law to all personnel involved in roadside care of accident victims. The Board of Trustees supported the bill.

The Commission was active in working for its passage, but the bill failed because of resistance by the State Highway Commission and private ambulance owners, who handle most emergency ambulances in small areas.

Plans are now being made by the Legislative Commission of the Association and the Indiana State Board of Health to introduce another bill which will, hopefully, be considered and passed by the 1972 General Assembly.

Among several points covered at the February 7 meeting of the Commission were the following, which the Commission feels should be included in this report for the information of ISMA members.

(1) The Highway Safety Act was passed in 1966 and it was felt that the area of emergency medical services was in need of a vast overhaul. Adequate first-aid training for personnel was very inadequate.

(2) Responsibility to develop better emergency medical services was assigned, in most states, to the Boards of Health. In Indiana it is the Indiana State Board of Health.

(3) The major objective of the emergency medical services plan is to transport the victim of an accident as quickly as possible to a location for definitive medical care, since 80% of deaths are during the period of time from the location to the source of care.

(4) *ISMA is urged to take a leadership role in the organization of Emergency Health Service Councils county-by-county. These councils could inventory their present services and recommend changes. The ISBH is in a position to assist these locally planned councils.*

(5) These councils do not have to await formation of Comprehensive Health Planning Councils but could easily become a subsection of such councils, once they are formed.

(6) ISBH is requesting $2 million for the next year to effect stimulation and operation of the emergency councils.

(7) The entire area of emergency medical services will be a continuous process of innovation and change.

CLEON M. SCHAUWECKER, M.D.
Chairman
JOHN G. SUELZER, M.D.
RAYMOND W. NICHOLSON, M.D.
NEAL E. BAXTER, M.D.
DONALD R. SHORTRIDGE, M.D.
CHARLES A. RAU, M.D.
WILLIAM W. DRUMMY, M.D.
HOWARD WILLIAMS, M.D.
JAMES W. KRESS, M.D.
FORREST J. BABB, M.D.
ROBERT M. BROWN, M.D.
JOHN S. FARQUHAR, JR., M.D.
JAMES D. FINFROCK, M.D.
WILLIAM F. KERRIGAN, M.D.
WILLIAM F. NOWLIN, M.D.

Governmental Medical Services

This Commission has met on several occasions during 1970-71 for the purposes of considering the business of the Medical Association in regard to state and federal and, in some areas, county involvement of the physicians of Indiana in medical services in these areas.

The CHAMPUS dependents medical care program was reviewed on a number of occasions as well as frequent telephone conferences to adjudicate questionable claims. The claims were satisfactorily processed and it is our impression that the OCHAMPUS headquarters in Denver was satisfied with our decisions and that the physicians concerned on the claims, except in probably one instance, concurred with the Commission's deliberation. I believe that the satisfaction of the physicians and also the fiscal agent was a direct result of this Commission's deliberations in 1970 where the usual and customary basis was adjusted to reflect the increase in fees in the state of Indiana.

Consideration of a relative value schedule for the use of the physicians of Indiana in determining fees and also allowing the various review commissions of the state and county societies to deliberate with fiscal agents was discussed. It is felt that, before a hard and fast recommendation can be made to the House of Delegates on this matter, some way must be found to determine what the usual and customary and reasonable fees are in the State of Indiana. This information probably could be obtained from insurance companies but they are reluctant to disclose their basis for determining indemnities. A postal canvass and survey of the physicians of Indiana is recommended to determine what their usual and customary and reasonable fees are in geographic areas. No cost estimate is available for this survey but it would certainly be most helpful in future decisions. If the survey is deemed unnecessary, it was the feeling of this committee that the 1969 California Relative Value Schedule is quite complete and has, in most areas, a reasonable unit value for services rendered. If the California Relative Value Schedule is used for Indiana, some modifications might be necessary in a few of the specialty areas with regard to the unit value, and an appropriate conversion factor could then be applied by the physicians in various geographic areas or throughout the state depending upon their requirements.

Another area of concern over the year was another way of delivering medical care to the indigent. The present Medicaid program on a fee-for-service basis is apparently fairly satisfactory to the Welfare Department for the cost of medical services per indigent person is now only $1 more per month than it was in 1968 when the original budget was conceived. The high cost of the program (1970—$57,000,000), however, was due to the twofold increase of indigent persons covered under the program. The Welfare Department feels, however, that they might economize further with total medical care under a foundation-type of medical service. The Welfare Department might be willing to allow a state or county medical foundation to completely administer and be the fiscal agent for the medical care of a certain geographic group of people and, in return, would pay what would amount to a premium per person covered under the plan. This will have to be considered at future meetings and also the feelings of the Board of Trustees must be considered as well as where other information is available from other Commissions.

The present proposed legislation in the U.S. Senate and Congress in regard to medical care for the indigent alone, or for the total population, has somewhat limited our ability to make a decision with regard to medical care for the indigent in the state of Indiana. We felt that to set up any plan or proposal at this time which might be negated in a year or two by a federal plan would only confuse the issue. Although the Welfare Department was quite pleased with the Medicaid program in our conferences with their chief administrator, Mr. William Sterrett, there were some instances—probably of overutilization—referred to the local county societies to be deliberated and some action taken. It would be our impression that satisfactory conclusions have been reached in all areas.

Also, with regard to Medicaid, there were lengthy meetings with the Blue Shield officers as well as an extensive tour of the Blue Shield facilities. We felt that we could better understand the fiscal problems involved in the complicated administration of the Medicaid program if we viewed their operation. A lengthy meeting was arranged and it seemed quite satisfactory. Blue Shield at the present time is processing Medicaid claims at 25% less than they had at the beginning of 1970. This is a low per-claim cost of $1.20, but the cost is diluted by the number of drug claims which require minimal processing. Blue Shield's regular business costs $3.40 to process and Medicare $3.10 to process. In 1970 an excess of two million claims were processed for an average of 41,000 Medicaid claims per week. The administrative efficiency now allows payment of 75% of these claims within two weeks. The major problem is in delaying payment, in determining patient eligibility, and also in erroneous completion of the claim forms in the physician's office. Claims review is required in a small percentage and, as noted above, only a few instances of over-utilization seem to occur. The Welfare Department is attempting to improve the basis for determining fees to July of 1970 as compared to the present 1969 basis at the 75th percentile.

The processing of a claim requires many steps, including microfilming, preparing tape for a computer and then on-line transmission to a computer processing center in Texas with a return the following day. Claims then are placed for payment shortly thereafter allowing for the rapid deliberation. With the 15 or 25% of claims that need to be rechecked and doctors' offices contacted for further information, the committee felt that some improvement could be made in this area to allow less handling. Possibly a common language could be used at the origin in the physician's office as well as through the computerization and payment of the claim. Here again a relative value schedule or procedural terminology book in each office and which is being used by the computer operator would speed up the processing and reduce the number of errors. Another concept considered by the Commission would be to place computer terminals of origin in county society offices or even having on-line computer mechanisms in the physician's office or if a group of physicians are together in a clinic or medical building with direct access to the main computer facilities. The cost of such an operation might be excessive to institute but possibly in the long-term function would reduce operative costs and speed up payment of claims.

A utilization review could be built into such a computer operation to allow for immediate review and possibly allow for fewer claims reviewed. If the mechanization or computerization of such a system originating in a county or a group of physicians' offices is not feasible, then possibly the distribution by the fiscal agent of Medicaid to the physicians' offices of a procedural terminology book with code numbers might enhance the processing. Since the claim forms need to originate in the physician's office, it would be no more of a problem for code numbers to be applied by the physician's employee to each procedure and diagnosis which then will allow one less step by the fiscal agent. This is time-consuming when 41,000 claims per week are being considered and, with the present rate of 69,000 claims per week with future increases, some simplification of the system must be found.

The Blue Shield has maintained that 70% of the physicians of Indiana have submitted Medicaid claims in 1970. On closer scrutiny and not being able to obtain exact breakdown information, the Commission determined that approximately 3% of the physicians of Indiana submitted claims that total 50% of the dollars paid to physician providers. In this instance these physicians were located in areas of high indigent population. Therefore, it would seem that the physicians of Indiana have cooperated with the Medicaid program as they wish with free choice of patient on their part. It also would seem that the indigent patient is receiving good medical care at a cost that is basically high, but which is a total-care plan. In discussing with other insurance companies the economics of a total-care plan, it would seem that the State of Indiana's present policy is fairly economical. Albeit the hospitals and providers of facilities are receiving total reimbursement of their fees but the physician is still receiving compensation on the basis of outdated fee schedules at the 75th percentile. This, of course, is partly regulated by the federal government and no local changes can be made. The Welfare Department, on the other hand, is attempting to improve this basis, realizing that Indiana physicians are personally involved in the care of their patients and also the cost of that care. One area we noted in which the cost might be reduced and errors avoided would be in a more efficient administrative processing of the claims either by local computer access or a coded relative value schedule.

The budget allowance for Medicaid for fiscal 1971 is $87 million. This is, then, an increase of 65% over 1970 and reflects an anticipated increase in eligible indigents, again probably 65% over 1970. This eligibility is a direct result of federal action and the local Welfare Department is helpless in two areas; namely, the inability to process as rapidly as they wish all supposed indigents and also the activities of welfare supporters in reducing the requirements for eligibility. The State of Indiana in 1970 was well below the local average of the United States in indigent persons. The national average is in the area of 6% as of January 1971, while Indiana reflected a 2.6% of the population. No plateau is in sight as the number continues to increase. The total welfare budget in the State of Indiana is in excess of $500 million and approximately $180 million is required from state funds.

The Welfare Department feels that the Blue Shield organization has been an adequate fiscal administrator of the Medicaid program, due to the fact that the costs of administering have been reduced gradually over 12 months and anticipated reductions are looked for in the future. The Welfare Department would consider a change only if the costs can be met or reduced even further.

Another area of deliberation for this Commission during 1971 was the Medicare program of care for the elderly and it would seem that this program is fairly well established, is regulated completely by the federal government, and local jurisdiction is minimal. Blue Shield processes these claims as well, except for the subsidiary benefits that the claimant might have. If it is Blue Shield subsidiary, this is processed under a separate division of Blue Shield. All claims must be processed through Baltimore's Social Security office to determine what deductibles the patient is still responsible for.

In conclusion, the Commission has met a number of times during the year and deliberated the above topics. Whether anything can be instituted—such as the relative value schedule for the physicians of Indiana or the use of a computerized local access system for Medicaid, or other forms-processing, or even the use of a procedural terminology with code numbers in the physician's office to facilitate Medicaid processing—this will only be known in the future.

I wish to thank the members of the Commission for their devotion to their work and also for the stimulating discussions in the forming of opinions that have been forthcoming.

It was a pleasure to serve as chairman of this commission during the year and I respectfully submit this report.

MICHAEL J. MASTRANGELO, M.D.
Chairman
COLA K. NEWSOME, M.D.
ROBERT D. ROBINSON, M.D.
FRANCIS H. GOOTEE, M.D.
FRANK BARD, M.D.
RENATE G. JUSTIN, M.D.
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GEORGE BRANAM, M.D.
LEE H. TRACHTENBERG, M.D.
GEORGE A. TEABOLDT, JR., M.D.
CHARLES R. ALVEY, M.D.
GLEN V. RYAN, M.D.
RAMON B. DuBOIS, M.D.
PAGE E. SPRAY, M.D.

Legislation

Your Commission on Legislation reports as follows:

During the 1971 General Assembly your commission held weekly meetings to study proposed legislation and to promulgate courses of action to be followed by our registered lobbyists.

Many bills were introduced in both the House and Senate having medical interest and in the course of the legislative procedure 14 Senate Enrolled Acts and 16 House Enrolled Acts became law. In all, your commission reviewed more than 200 bills and resolutions.

It will be the purpose of this report to point out highlights of these new laws, to comment on some which did not pass and

to mention legislation we should consider for the next session which will be in January 1972.

It should be pointed out that changes have taken place within the workings of the Indiana General Assembly which will have a definite effect on the pattern of lobbying in the future.

The first is that annual sessions will be held. The second is the creation of the Legislative Council. These two changes mean that our future lobbying efforts will have to be a year round affair rather than once every two years.

The existence of the Legislative Council mitigates the role of the individual Legislator in introducing bills. In this new arrangement bills are to be put through the Legislative Council first before they are pre-filed, introduced and considered on the floor.

Our first consideration will be a rundown on the new legislation. We will take the Senate Enrolled Acts First:

S.E.A. 2 (Establishes Commission on Higher Education)—This new commission will have the power to review both budget and curriculum of the several state supported post-high-school educational institutions. Since medical education is included in this category, it can be seen that future acts of the Commission could have a tremendous impact on decisions regarding the course medical education may take in Indiana.

S.E.A. 19 (Reporting Blindness and Visual Impairment)—This amends a 1949 law which requires every licensed physician to report to the State Board of Health cases of serious visual impairment under penalty of a $25 fine for failure to report. The new law includes optometrists among those having to report.

S.E.A. 148 (New Nursing Regulations)—In effect, this is a brand new nursing law. It differentiates between registered nurses and licensed practical nurses and sets forth the qualifications for both.

S.E.A. 164 (Community Health Centers)—Provides for funding of local community mental health centers through taxation at the local level at the rate of four cents on every $100 of taxable property.

S.E.A. 221 (Hospital Admission of the Mentally Ill)—Updates the proceedings for the admission of the mentally ill to psychiatric hospitals. (Physicians concerned should read the provisions in detail).

S.E.A. 290 (Drug Abuse Omnibus Bill)—There were a number of bills having to do with drug abuse and drug education introduced in the 1971 session. In general, they were lumped together into this one bill. It provides for methadone treatment for addicts under controlled rehabilitative programs and has a number of other features, all of which will be under the supervision and control of the Indiana Department of Mental Health.

S.E.A. 296 (New Positions in Department of Mental Health)—This defines responsibilities and adds new classifications in the department of mental health, and maintenance of patients in psychiatric hospitals.

S.E.A. 309 (Narcotic Drugs)—This removes marijuana from the list of narcotic drugs and, in some instances, redefines and updates the general definitions of the narcotic drugs.

S.E.A. 311 (Hospital Committee Records Confidential)—Hereafter, all members of duly constituted hospital review committees (e.g. tissue committee) have absolute immunity from civil liability. This immunity also applies to committee reports, records and recommendations made to the governing board of the hospital.

S.E.A. 315 (Dangerous Drugs)—This is a companion measure to S.E.A. 309 (see above) which makes marijuana a "dangerous drug" rather than a "narcotic drug." There is also in this bill some redefinition of those drugs classified as "dangerous."

S.E.A. 388 (Fort Wayne TB Hospital)—Redefines the population levels pertinent to this facility and sets up the board of managers for the facility.

S.E.A. 459 (Chemical Test for Intoxication)—This is a revision of the state's implied consent law; adds drugs and also adds "probable cause." Does not change alcohol content level.

S.E.A. 470 (Regulation of the Practice of Physical Therapy)—All this bill does is to provide for a "physical therapist's assistant."

S.E.A. 601 (Radiation Control)—All this does is to provide regulations governing microwave ovens. It has nothing to do with the practice of radiology.

H.E.A. 1102 (Blood Is a Service)—This was a major legislative victory for ISMA and the allied health professions and hospitals. In response to the ISMA House of Delegates' 1970 mandate, your commission on legislation actively supported this bill which makes blood, blood products, as well as other human tissue, a service and not a product and therefore not warrantable, which should release doctors, hospitals, blood banks, donors and others concerned from liability in the event that a person suffers an untoward result from a transfusion or transplant.

H.E.A. 1127 (Rehabilitative Services for the Multiply Handicapped)—This is an initial step which, it is hoped, will lead to a strong program in Indiana. Token appropriations were provided.

H.E.A. 1128 (Immunization of Children)—Adds to the existing law the immunization for "German measles" and tests for Sickle cell anemia.

H.E.A. 1129 (TB Skin Tests)—Requires children to be given TB skin tests within 30 days of enrollment in school in kindergarten or first grade.

H.E.A. 1154 (Renal Disease)—Under this bill, the Legislature appropriated $500,000 for the biennium to cover renal dialysis. Another victory—as the House of Delegates adopted a resolution requesting this law.

H.E.A. 1176 (Setting Salaries of Board of Health Personnel)—This bill in its original form met strong opposition from your ISMA because the bill would have given to the county council the power to set ALL local health department salaries. As amended, the county council has power over the salaries of only the clerical personnel in a county health department, not the professional personnel.

H.E.A. 1215 (Accreditation of Private Schools)—All private vocational schools in the state of Indiana must be accredited and meet state standards. This should eliminate fly-by-night schools "guaranteeing" jobs for students who enroll in their ancillary medical training programs.

H.E.A. 1260 (Foreign Physicians)—A book could be written on the ISMA activities in connection with this subject. ISMA members are strongly urged to read the text of this Act. A waiver clause, that did not exist in the laws before, now gives the Indiana State Board of Medical Registration and Examination the right to waive certain requirements when an individuals' credentials warrant this.

H.E.A. 1309 (New County Hospital Law)—This is a complete recodification of the state's county hospital laws, with considerable modernizing. The bill repeals all existing county hospital laws. (Your hospital administrator should have a copy of this new law which you may care to review in detail.)

H.E.A. 1347 (Criminal Sex Deviation)—This bill adds a new chapter to Indiana law to provide for outpatient commitment of persons not convicted of, nor charged with, nor on probation for, commission of a violent sexual crime or a sexual crime against someone under age 16. (Physicians concerned should refer to the text of the law.)

H.E.A. 1430 (Seven Regional Medical Centers)—As mandated by the 1970 House of Delegates, your Commission on Legislation supported this bill which establishes the Indiana Statewide Medical Education System.

H.E.A. 1436 (Medical Advisory Commission)—Adds an optometrist to the medical advisory commission on driver li-

censure of the Indiana Bureau of Motor Vehicles.

H.E.A. 1551 (Control of Phosphates)—Due in part to strong support from the ISMA, Indiana became the first state to put rigid controls on sale and use of detergents containing phosphate compounds. It reduces the content to 12% by weight or volume after Jan. 1, 1972 and 3% after Jan. 1, 1973.

H.E.A. 1679 (Health Officer Subpoena Powers in Ordering Autopsies)—In effect, this bill strengthens the hand of the local health officer in getting valid information as to the cause of death in questionable cases or in the case of the stillborn.

H.E.A. 1719 (Good Samaritan)—In this law the General Assembly adopted the law of the State of North Carolina which does not specify occupations or professions or competency of individuals rendering aid at the scene of an emergency and holding all such persons free from liability except for gross negligence.

The second phase of this report has to do with some of the legislation that did not pass.

Of greatest concern was the emergency ambulance bill which failed primarily because of the $5 million per annum price tag. There were some other factors, such as last minute opposition from the funeral directors and the volunteer firemen groups, particularly those within the Indianapolis metropolitan community.

Also of concern was the defeat by ISMA and other groups of S.B. 120, which was a workman's compensation measure. In its original form it granted an employe the right to choose his own physician, dentist or podiatrist after 60 days. The bill was later amended to include "chiropractors" and was further amended to define a chiropraetor as a physician. The bill barely squeaked through the House and Senate, but was vetoed by the Governor. The veto was then sustained in the Senate and the bill was lost. This bill represents what we face in almost every session—pressure from the chiropractors to improve their lot.

Although the House of Delegates mandated that ISMA support legislation for the control of the environment, your Commission on Legislation had to take a position of opposition to the major bill as introduced—The Environmental Management Act—because it removed the environmental control functions from the Indiana State Board of Health and created a super board with "outlandish" salaries and awesome powers. There was nothing wrong with the intent of the bill, only with the method and implementation.

A bill for creation and regulation of physicians' assistants was introduced in the Senate, but at our request it was held in committee and allowed to die because of problems of definition and some opposition that arose from some unexpected quarters.

As in past sessions, a bill to create the position of medical director in the Department of Corrections failed.

Also failing was the safety glazing bill, but we have information that this may be changed by a new regulation in the state building code and may not require a new law.

As to the future, your Commission has been meeting this summer and looks forward to the reintroduction of the emergency ambulance bill in the next session of the General Assembly.

The commission also has under consideration measures having to do with environmental control, medical discipline, changes in the medical practices act and will be reviewing other measures affecting the practice of medicine and the delivery of health care as they arise.

Medical Disciplinary Act. In accordance with the action of the House of Delegates in 1970, your commission has studied medical disciplinary procedures and has prepared a bill for introduction in the 1972 session of the General Assembly. This bill, as prepared, is taken from the Washington State Medical Association bill. That association reports that it has had this procedure in operation for many years and considers it very successful. Before introducing this bill, however, we desire the approval of the House of Delegates. The proposed bill follows:

Section 1. Declaration of purpose. This chapter is passed:

(a) In the exercise of the police power of the state to protect public health, to promote the welfare of the state, and to provide an adequate public agency to act as a disciplinary body for the members of the medical profession licensed to practice medicine, surgery or obstetrics in this state;

(b) Because the health and well-being of the people of this state are of paramount importance;

(c) Because the conduct of members of the medical profession licensed to practice medicine, surgery or obstetrics in this state plays a vital role in preserving the health and well-being of the people of the state; and

(d) Because the agency which now exists to handle disciplinary proceedings for members of the medical profession licensed to practice medicine, surgery or obstetrics in this state is ineffective and very infrequently employed, and consequently there is no effective means of handling such disciplinary proceedings when they are necessary for the protection of the public health.

Section 2. Definitions. Terms used in this chapter shall have the meaning set forth in this section unless the context clearly indicates otherwise:

(a) "Board" means the medical disciplinary board.

(b) "License" means a license to practice medicine, surgery or obstetrics in this state as provided in Acts 1897, Ch. 169, Section 1, page 255 et seq.

(c) "Members" means members of the medical disciplinary board.

(d) "Secretary" means the secretary of the medical disciplinary board.

Section 3. "Unprofessional conduct." The term "unprofessional conduct" as used in this chapter shall mean the following items or any one or combination thereof:

(a) Conviction in any court of any offense involving moral turpitude, in which case the record of such conviction shall be conclusive evidence;

(b) The procuring, or aiding or abetting in procuring a criminal abortion;

(c) Fraud or deceit in the obtaining of a license to practice medicine;

(d) All advertising of medical business which is intended or has a tendency to deceive the public or impose upon credulous or ignorant persons and so be harmful or injurious to public morals or safety;

(e) The impersonation of another licensed practitioner;

(f) Habitual intemperance;

(g) The use or prescription for use of narcotic drugs in any way other than for therapeutic purposes;

(h) The offering, undertaking or agreeing to cure or treat disease by a secret method, procedure, treatment, or medicine, or the treating, operating, or prescribing for any human condition by a method, means, or procedure which the licensee refuses to divulge upon demand of the board;

(i) The wilful betrayal of a professional secret;

(j) Repeated acts of immorality;

(k) Repeated acts of misconduct in the practice of the profession;

(l) Repeated acts of malpractice;

(m) The acceptance of any rebate or other compensation for any referral of a patient;

(n) Aiding or abetting an unlicensed person to practice medicine; or

(o) Declaration of mental incompetency by a court of competent jurisdiction.

Section 4. Board created-Composition-Legal advisor. There is hereby created the "Indiana State Medical Disciplinary Board," which shall be composed of one

holder of a valid license to practice medicine, surgery or obstetrics from each federal congressional district now existing or hereafter created in this state. The board shall be an administrative agency of the state of Indiana. The attorney general shall be the advisor of the board and shall represent it in all legal proceedings.

Section 5. Election of Members. Members of the board shall be elected by secret mail ballot by the holders of licenses to practice medicine, surgery or obstetrics residing in each federal congressional district and shall hold office until their successors are elected and qualified. Members from even-numbered federal congressional districts shall be elected in even-numbered years and members from odd-numbered federal congressional districts shall be elected in odd-numbered years.

Section 6. Nominations. Nominations to the board may be made by petition signed by not less than twenty-five license holders residing in the nominee's district, and shall be submitted to the board at least four weeks prior to the date of the election. Votes cast for license holders not so nominated shall be valid.

Section 7. Date of election-Commencement of term. The election shall be held in September and shall be conducted in accordance with rules and regulations adopted by the board under the rule-making power hereinafter provided for. Terms of office of members shall commence on October 1st.

Section 8. Vacancies. Any vacancies in the board shall be filled by the governor by appointment from the federal congressional district in which the vacancies occurred, and a member appointed to fill a vacancy on the board shall serve until the naming of his successor in the next district election and until his successor takes office on the October 1st following the election.

Section 9. Removal of members. Any member of the board may be removed by the governor for neglect of duty, misconduct or malfeasance or misfeasance in office, after being given a written statement of the charges against him and sufficient opportunity to be heard thereon.

Section 10. Compensation and reimbursement of members. Members of the board shall be paid twenty-five dollars per diem for time spent in performing their duties as members of the board and shall be repaid their necessary traveling and other expenses while engaged in business of the board, with such per diem and reimbursement for expenses to be paid out of the general fund on properly approved vouchers: *Provided*, That the amount for expense will not be more than fifteen dollars per day, except for traveling expense which shall not be more than eight cents per mile.

Section 11. Territorial scope of operations. The board may meet, function, and exercise its powers at any place within this state.

Section 12. Organization of first board. The first board shall be organized in this manner: Within ten days after the effective date of this chapter the governor shall appoint five holders of licenses to practice medicine, surgery or obstetrics in this state to serve as members of a temporary commission which shall, within ninety days thereafter, organize and hold the election to name the first members of the medical disciplinary board. The temporary commission shall adopt such rules and regulations as it deems necessary to govern the holding of the first election. After the election is completed and the first members of the board have qualified and taken office, the temporary commission shall be abolished and all of its records shall be turned over to the board.

Section 13. Officers-Meetings-Quorum. The board shall elect from its members a chairman, vice-chairman, and secretary, who shall serve for one year and until their successors are elected and qualified. The board shall meet at least once a year or oftener upon the call of the chairman at such times and places as the chairman shall designate. A majority of the board members shall constitute a quorum to transact business.

Section 14. Immunity from suit. Members of the board shall be immune from suit in any action, civil or criminal, based upon any disciplinary proceedings or other official acts performed in good faith as members of such board.

Section 15. Powers and duties. The board shall have the following powers and duties.

(a) To adopt, amend and rescind such rules and regulations as it deems necessary to carry out the provisions of this chapter;

(b) To investigate all complaints and charges of unprofessional conduct against any holder of a license and to hold hearings to determine whether such charges are substantiated or unsubstantiated;

(c) To employ necessary stenographic or clerical help;

(d) To issue subpoenas and administer oaths in connection with any investigation, hearing, or disciplinary proceeding held under this chapter;

(e) To take or cause depositions to be taken as needed in any investigation, hearing, or proceeding.

Section 16. Complaints-Hearing committee. Any person, firm, corporation or public officer may submit a written complaint to the secretary charging the holder of a license to practice medicine, surgery or obstetrics with unprofessional conduct, specifying the grounds therefor. If the board determines that such complaint merits consideration, or if the board shall have reason to believe, without a formal complaint, that any holder of a license has been guilty of unprofessional conduct, the chairman shall designate three members to serve as a committee to hear and report upon such charges.

Section 17. Specification of charges. When a hearing committee is named, the secretary shall prepare a factual specification of the charge or charges of unprofessional conduct made against a license holder, a copy of which shall be served upon the accused, together with a notice of the hearing, said notice to be served in the manner and as provided in the Administrative Adjudication and Court Review Act of 1947 (Acts 1947, Ch. 365, Section 1 et. seq., as amended).

Section 18. Time, notice, of hearing. The time of hearing shall be fixed by the secretary as soon as convenient, but not earlier than thirty days after service of the charges upon the accused. The secretary shall issue a notice of hearing of the charges, which notice shall specify the time and place of hearing and shall notify the accused that he may file with the secretary a written response within twenty days of the date of service. Such notice shall also notify the accused that a stenographic record of the proceeding will be kept, that he will have the opportunity to appear personally and to have counsel present, with the right to produce witnesses and evidence in his own behalf, to cross-examine witnesses testifying against him, to examine witnesses testifying for him, to examine such documentary evidence as may be produced against him, and to have subpoenas issued by the board.

Section 19. Subpoenas-Contempt. Subpoenas issued by the board to compel the attendance of witnesses at any investigation or hearing shall be served and enforced in accordance with the provisions of Section 21 of the Administrative Adjudication and Court Review Act of 1947 as amended (Acts 1947, Ch. 365, Section 21).

Section 20. Report of hearing. Within a reasonable time after holding a hearing under the provisions of Section 18, the committee shall make a written report of its findings of facts and its recommendations, and the same shall be forthwith transmitted to the secretary, with a transcript of the evidence.

Section 21. Hearing before full board. If the board deems it necessary, the board may, after further notice to the accused, take further testimony at a second hear-

ing before the full board, conuducted as provided for hearings before the three man hearing committee.

Section 22. Basis for board's determination. In any event, whether the board makes its determination on the findings of the hearing committee or on the findings of the committee as supplemented by a second hearing before the board, the board shall determine the charge or charges upon the merits on the basis of the evidence in the record before it.

Section 23. Certificate of revocation or suspension-Reprimand. If a majority of the members of the board then sitting vote in favor of finding the accused guilty of unprofessional conduct as specified in the charges, or any of them, the board shall prepare written findings of fact and may thereafter prepare and file with the Clerk of the Circuit Court of the County in which such license was issued a certificate or order of revocation or suspension, and such Clerk shall record the same upon the margin of the record of such license, and a copy of said certificate or order shall also be served upon the accused. In the alternative, the board may reprimand the accused, as it deems most appropriate.

Section 24. Dismissal of charges—Exoneration. If the license holder is found not guilty, or if less than a majority of the members then sitting vote for a finding of guilty, the board shall forthwith order a dismissal of the charges and the exoneration of the accused. When a proceeding has been dismissed, either on the merits or otherwise, the board shall relieve the accused from any possible odium that may attach by reason of the charges made against him by such public exoneration as is necessary, if requested by the accused to do so.

Section 25. Revocation or suspension of license-Stay pending review. The filing by the board with the Clerk of the Circuit Court of the County in which such license was issued of a certificate or order of revocation or suspension after due notice, hearing and findings in accordance with the procedures specified in this chapter, certifying that any holder of a license has been found guilty of unprofessional conduct by the board, shall constitute a revocation or suspension of the license to practice medicine, surgery or obstetrics in this state in accordance with the terms and conditions imposed by the board and embodied in the certificate or order of revocation or suspension: *Provided*, That if the licensee seeks judicial review of the board's decision pursuant to the provisions of this chapter, such revocation or the period of such suspension shall be stayed and shall not be effective or commence to run until final judgment has been entered in any proceeding instituted under the provisions of this chapter and the licensee's judicial remedies exhausted hereunder.

Section 26. Contents of certificate—Recording. The certificate or order of revocation or suspension shall contain a brief and concise statement of the ground or grounds upon which the certificate or order is based and the specific terms and conditions of such revocation or suspension.

Section 27. Issuance of license after revocation or suspension. No license or any renewal thereof shall be issued to any person whose license has been revoked or suspended by the board except in conformity with the terms and conditions of the certificate or order of revocation or suspension, or in conformity with any order of reinstatement issued by the board, or in accordance with the final judgment in any proceeding for review instituted under the provisions of this chapter.

Section 28. Appeal from decision of board. The procedure for an appeal from any decision of the board shall be governed by Sections 14-19 of the Administratrix Adjudication and Court Review Act of 1947 as amended from time to time (Acts 1947, Ch. 365, Sections 14-19).

JAMES M. KIRTLEY, M.D., *Chairman*
ROBERT E. ARENDELL, M.D.
JOSEPH D. McPIKE, M.D.
LESLIE M. BAKER, M.D.
FRED W. DIERDORF, M.D.
JOSEPH C. FINNERAN, M.D.
JACK L. ALEXANDER, M.D.
MAX N. HOFFMAN, M.D.
E. L. C. BROOMES, M.D.
LESTER RENBARGER, M.D.
DeWAYNE L. HULL, M.D.
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DONALD R. TAYLOR, M.D.
ROBERT E. ROSE, M.D.

Resolutions

Amendments to the Constitution to be Voted on at Indianapolis Session, 1971

At the 1970 annual convention at South Bend, the House of Delegates adopted the report of the Reference Committee on Amendments to the Constitution and Bylaws, in which the Reference Committee recommended for adoption the following amendments to the Constitution:

Be It Resolved that Article VI of the Constitution be amended by deleting the last sentence of the Article which reads "seven trustees shall constitute a quorum" and insert in lieu thereof "A majority of elected trustees shall constitute a quorum."

Be It Resolved that the present Section 3 of Article VIII be deleted and the following be inserted in lieu thereof: "Section 3. Special meetings of either the association or the House of Delegates shall be called by the president upon receipt of a petition signed by thirty delegates or one hundred members. The signed petition shall contain the names of at least ten delegates or thirty-four members from each of at least three Board districts. Upon receipt by the president of such a petition, the president shall within thirty days thereafter issue a call for such special meeting at a time and place to be fixed by the president. The president, in specifying the time of such special meeting, shall fix the same as soon thereafter as reasonable and suitable arrangements can be made."

Be It Resolved that Article IX, Section 1, be amended by striking the "thirteen" and inserting in lieu thereof the word "the" which will then make Section 1 read as follows: "Section 1 - The officers of this Association shall be a President, a President-elect, an Executive Secretary, a Treasurer, an Assistant Treasurer and the Trustees, each of whom shall be a member, except the Executive Secretary, who need not necessarily be either a physician or a member."

Be It Resolved that Article IX, Section 4, be amended by striking the word "Trustee" in the first sentence and inserting in lieu thereof the following:
"Trustee(s) or alternate Trustee(s)" which will make Section 4 then read as follows: "Section 4 - The Trustees shall be elected by the respective district societies. If any district fails to meet and elect its Trustee(s) or alternate Trustee(s) by the time of the expiration of the incumbent's term of office, the Executive Secretary of the Association shall cause a special meeting to be called by said district society for the purpose of such election."

Be It Resolved that Article IX, Section 5 be amended by striking the word "an" in the first sentence and adding after the word Trustee "(s)" which will make Section 5 then read as follows: "Section 5. Each Trustee district shall elect alternate Trustee(s) whose term of office shall be the same as the Trustee, namely three years. The Alternate Trustee shall be elected in a year during which there is no Trustee elected.

"The duties of the alternate Trustee shall be:

1. To represent the Trustee district in the absence of the regularly elected Trustee.
2. To vote only in the absence of the regularly elected Trustee either in the House of Delegates or in Board meetings where he represents the regularly elected Trustee."

Resolution No. 71-1

Introduced by: SIXTH DISTRICT MEDICAL SOCIETY

Subject: ELECTION OF ALTERNATE DIRECTOR TO BLUE SHIELD

Referred to: REFERENCE COMMITTEE No. 1

WHEREAS, the Sixth District Medical Society has become aware that for continuity there should also be an alternate director for the director on the Board of Mutual Medical Insurance, Inc. (Blue Shield); and

WHEREAS, by having an alternate director it would serve to provide an educational experience for an individual who might at some time succeed to the directorship and also would permit the district to be represented in the absence of the regular director;

NOW, THEREFORE, BE IT RESOLVED, that Chapter XXXII of the Bylaws of the Indiana State Medical Association be amended by adding a Section 11 to read as follows:

"Section 11. It shall be the duty of each district medical society to select in any manner it chooses a member of its district to serve as an alternate director on the Board of directors of Mutual Medical Insurance, Inc. (Blue Shield). Said alternate director may be elected in the same year as the director and the results of such election shall be immediately transmitted to the Board of Trustees of the Indiana State Medical Association which will officially place said selected member in nomination for said Board of Directors. The term of office of the alternate director shall be the same as that of the director." and,

BE IT FURTHER RESOLVED, that the Indiana State Medical Association formally petition the Board of Directors of Mutual Medical Insurance, Inc. (Blue Shield) to change their bylaws, if necessary, to permit the election of an alternate director who shall have the full powers and duties of the director in the absence of the director but shall not have the power to vote but shall have the power of discussion when the regular director is present in the regular meeting of the directors.

Resolution No. 71-2

Introduced by: GRANT COUNTY MEDICAL SOCIETY

Subject: RESTRICTIVE COVENANTS - DECLARED UNETHICAL

Referred to: REFERENCE COMMITTEE NO. 3

WHEREAS, restrictive covenants in contract clauses between groups or individual physicians tend to infringe upon the civil rights of the individual when enforced; and,

WHEREAS, more and more medical practice corporations and partnerships are being formed in Grant County and throughout the State of Indiana; and,

WHEREAS, many physicians of great talent and ability have had to leave the area because of such restrictive covenants; and,

WHEREAS, each time a physician leaves our community, a gap appears in the medical care available to the citizenry; and

WHEREAS, the continued enforcement of such restrictive covenants in the area tend to discourage the arrival of new physicians; and

WHEREAS, one of the purposes of organized medicine is to promote the health of the nation;

THEREFORE, BE IT RESOLVED that the Grant County Medical Society hereby goes on record as opposing restrictive covenant contracts between physicians and henceforth will consider such contracts in violation of its purpose, and therefore not in keeping with good ethical practice between physicians,

BE IT FURTHER RESOLVED that the delegate to Indiana State Medical Association for Grant County Medical Society be instructed to present this resolution or a similar resolution of the same intent before the Indiana State Medical Association House of Delegates at its next annual meeting.

Resolution No. 71-3

Introduced by: DELAWARE-BLACKFORD COUNTY MEDICAL SOCIETY

Subject: DECLARATION OF NON-PARTICIPATION POLICY

Referred to: REFERENCE COMMITTEE NO. 1

WHEREAS, the free enterprise, fee-for-service system of medical practice in the United States makes most efficient use of available medical personnel, encourages high quality medical care, and preserves the freedom of patient and doctor; and

WHEREAS, government intervention between practicing physicians and the patient historically removes responsibility from both parties and leads to decreasing quality of medical care; and

WHEREAS, the current proposals for Federal regimentation of medical care which are before the Congress (Senate Bill 3 and H.R. 7741) will result in total control of all patients and all doctors, with no free choice alternative; and

WHEREAS, the members of the Indiana State Medical Association wish to continue to provide medical services in the most efficient manner, retaining freedom of choice for physician and patient alike, and retaining mutual respect and responsibility between patient and physician; and

WHEREAS, no plan of socialized medicine or other form of government-sponsored health care plan can function without cooperation and participation of the majority of physicians of the involved community;

NOW, THEREFORE, BE IT RESOLVED that the members of the Indiana State Medical Association in their effort to help preserve the American system of medicine, and to thwart the promulgation of a national socialist medical system do pledge ourselves to continue to care for our patients to the best of our ability, and do hereby notify the members of the Federal Congress and the general public that we will not participate in any Federally sponsored plan of collectivized medical care now under consideration, including Senate Bill 3 or H.R. 7741, or any other such plan which may in the future be considered, if such plan includes provisions for: abandonment of fee-for-service system, forced abolition of individual patient-doctor relationship with separate responsibility, national licensure of medical practitioners, forced relocation of physicians, involuntary servitude of physicians, abridgement of the right of privileged communication between the patient and doctor, institution of compulsory peer review requirements, establishment of any Federal regulations of medical practice except in the distribution of narcotics and dangerous drugs, the removal of constitutional freedoms from any citizen.

Resolution No. 71-4

Introduced by: LA PORTE COUNTY MEDICAL SOCIETY

Subject: MEDICAL DEPARTMENT-BOARD OF CORRECTIONS

Referred to: REFERENCE COMMITTEE NO. 3

WHEREAS, many members of the LaPorte County Medical Society have either worked in the Michigan City prison medical department or have served as consultants and are aware of the medical needs of the inmates of the Michigan City prison; and,

WHEREAS, the LaPorte County Medical Society has annually for the past nine years recommended to the state government through the state medical association the idea of organizing the medical care in the Department of Corrections in a more efficient manner; and,

WHEREAS, a survey of the medical needs of our state prisons by the U.S. Public Health Department in 1968 confirmed this recommendation; and,

WHEREAS, the Indiana State Board of Corrections is responsible for the total care of all inmates under their supervision;

NOW, THEREFORE, BE IT RESOLVED that the LaPorte County Medical Society urges the Indiana State Medical Association to again recommend to the state government the establishment of a medical department within the Board of Corrections.

Resolution No. 71-5

Introduced by: LA PORTE COUNTY MEDICAL SOCIETY

Subject: STATE-WIDE MORATORIUM ON AMPHETAMINE DRUGS

Referred to: REFERENCE COMMITTEE NO. 2

WHEREAS, the medical profession recognizes the seriousness of the drug-abuse problem in this country, and,

WHEREAS, the medical profession should lead in studying and establishing solutions to the problems of drug abuse; and,

WHEREAS, the LaPorte County Medical Society has had some success, a great deal of cooperation from the pharmacists and a great deal of public relations with a program which established a three months' moratorium on the prescribing of amphetamine drugs by the members;

NOW, THEREFORE, BE IT RESOLVED that the LaPorte County Medical Society recommends to the Indiana State Medical Association that a statewide moratorium be established on the prescription of amphetamine drugs by their members except in the treatment of narcolepsy, hyperkineses and certain psychiatric problems.

Resolution No. 71-6

Introduced by: VANDERBURGH COUNTY MEDICAL SOCIETY

Subject: CHLORINE CONTENT-SWIMMING POOLS

Referred to: REFERENCE COMMITTEE NO. 5

WHEREAS, Indiana State law requires the addition of chlorine to swimming pools in order to insure safe water for swimming; and

WHEREAS, the addition of too much chlorine to an indoor pool may result in an unhealthy level of free chlorine in the air above the pool; and

WHEREAS, this may produce bronchospasm or other respiratory difficulties in susceptible individuals; and

WHEREAS, no upper limit has been set by the State for the amount of chlorine which may be added to indoor pools;

NOW, THEREFORE BE IT RESOLVED, that the State be urged, through whatever means or mechanism may be appropriate, to establish a safe upper limit for the addition of chlorine in indoor swimming pools.

Resolution No. 71-7

Introduced by: VANDERBURGH COUNTY MEDICAL SOCIETY

Subject: INVASION OF PATIENT PRIVACY

Referred to: REFERENCE COMMITTEE NO. 5

WHEREAS, the State Health Commissioner, in accord with provisions of Chapter 404, Indiana Acts of 1969, has forwarded to Indiana physicians, directors and superintendents of agencies and facilities a form on which information about individuals with handicapping conditions is to be recorded; and

WHEREAS, a handicapping condition is very broadly defined therein and may include any problem of vision, hearing, speech, mental retardation, emotions or mind, chronic diseases and conditions, and physical handicaps, even extending to such conditions as unusually low voice, sinus trouble, varicose veins, or birthmarks, providing only that in the doctor's judgment said condition prevents the individual from engaging in normal life activities, and the individual can benefit from habilitation or rehabilitation services; and

WHEREAS, the requested information not only identifies an individual as handicapped, but also provides medical information which a patient would ordinarily assume to be confidential and unavailable to anyone outside his doctor's office without the express permission of the patient; and

WHEREAS, compliance with the law seems to constitute a clear invasion of the patient's privacy; and

WHEREAS, such compliance would also be an intrusion of the government into the doctor-patient relationship;

NOW, THEREFORE, BE IT RESOLVED that the Indiana State Medical Association register a protest with the State Board of Health; and

FURTHER BE IT RESOLVED that it employ any other feasible and legal means, including support of legislative action, if indicated, to safeguard the privacy of the patient and to maintain the sanctity of the doctor-patient relationship without in any way limiting the opportunity of any individual to apply for aid for handicapped persons.

Resolution No. 71-8

Introduced by: INDIANA CHAPTER AMERICAN ACADEMY OF PEDIATRICS

Subject: NEWBORN INSURANCE COVERAGE

Referred to: REFERENCE COMMITTEE NO. 1

WHEREAS, it is recognized that the nation's most valuable resource is its children; and

WHEREAS, it is recommended that every infant receive quality medical supervision in the earliest period of life; and

WHEREAS, the private insurance industry, including Blue Shield, offers exclusion from coverage for the first fourteen days of life in many policies, and

WHEREAS, certain health problems in children are readily identified and best treated in the first days of life and, consequently, this exclusion is not for the benefit of child health nor the family's well-being;

THEREFORE, BE IT RESOLVED that the Indiana State Medical Association vigorously supports the eradication of the 14-day exclusion clause from all health insurance policies sold in the state.

Resolution No. 71-9

Introduced by: CLINTON COUNTY MEDICAL SOCIETY

Subject: DISASSOCIATION: ISMA-AMA

Referred to: REFERENCE COMMITTEE #1

WHEREAS, the American Medical Association no longer gives whole-hearted support in the fight against the socialistic schemes of our government; and,

WHEREAS, the American Medical Association, in lieu of fighting the socialistic schemes, has merely offered equally odious alternatives; and

WHEREAS, the hierarchy of the American Medical Association under the tutelage and leadership of Dr. Ernest Howard, who has consistently undercut various leaders in our fight against collectivism—such as Dr. Edward Annis, Dr. F. J. L. Blasingame, and Dr. Milford Rouse; and

WHEREAS, much of our monies given as dues to the American Medical Association are actually used to promote our own downfall and for innumerable publications of dubious worth to our medical profession;

THEREFORE, BE IT RESOLVED that a committee be appointed at the next regular meeting of the House of Delegates of the Indiana State Medical Association to study the advisability and feasibility of the Indiana State Medical Association disassociating itself from the American Medical Association.

The above resolution was passed by the Clinton County Medical Society at its regular, stated meeting, May 25, 1971, for submission to the House of Delegates of the Indiana State Medical Association.

Resolution No. 71-10

Introduced by: FORT WAYNE-ALLEN COUNTY MEDICAL SOCIETY

Subject: FORMATION — BARGAINING COMMITTEE

Referred to: REFERENCE COMMITTEE #5

WHEREAS, Indiana State Medical Association members feel the need for a bargaining committee; and

WHEREAS, third parties are approaching the Indiana State Medical Association to deal with mutual problems; and

WHEREAS, Conditions which formerly precluded such a committee are changing;

NOW, THEREFORE, BE IT RESOLVED that the Indiana State Medical Association form a bargaining committee whose action shall be to improve the Indiana State Medical Association members' economic advantage in dealing with all third parties, whether governmental or business or intermediary.

Resolution No. 71-11

Introduced by: DECATUR COUNTY MEDICAL SOCIETY

Subject: SUPPORT OF ANNUAL MEETING PROGRAM

Referred to: REFERENCE COMMITTEE NO. 3

WHEREAS, one of the vital services of the Indiana State Medical Association to its membership is the providing of a maximal, informative and comprehensive coverage of medical, scientific and socio-economic and political trends in the practice of medicine at the Annual Convention; and

WHEREAS, speakers of unique or unusual, or comprehensive experience, national repute or recognized capacities in their respective fields of medical, scientific or socio-economic or political trends in the practice of medicine are essential to providing this maximal, informative and comprehensive coverage; and

WHEREAS, the Convention Arrangements Commission and Section Officers and those concerned with providing the program for the Annual Meeting are greatly hampered in their efforts to provide a program of maximal comprehensive coverage by the inability to offer adequate or usual and customary honorariums to the speakers;

NOW, THEREFORE, BE IT RESOLVED that the Commission on Convention Arrangements be provided with adequate funds up to three dollars ($3.00) per member of the Association for the specific purpose of honorariums for speakers at the Annual Meeting of the Association.

Resolution No. 71-12

Introduced by: BOARD OF TRUSTEES, INDIANA SOCIETY OF INTERNAL MEDICINE

Subject: AMA CODING AND NOMENCLATURE SYSTEM

Referred to: REFERENCE COMMITTEE NO. 2

WHEREAS, the need for a uniform system of coding and nomenclature in order to describe accurately the great variety of medical services has never been greater; and

WHEREAS, the American Medical Association has prepared an accurate and current system of coding and nomenclature; and

WHEREAS, 28 state medical societies, many specialty societies, the Health Insurance Council and the World Medical Association, list attached, have adopted the AMA Current Procedural Terminology (CPT); and

WHEREAS, this is now universally used for the description of professional services;

THEREFORE, BE IT RESOLVED that the Indiana State Medical Association officially adopt this system of nomenclature of the American Medical Association; and

BE IT FURTHER RESOLVED that the ISMA House of Delegates urge Indiana Blue Shield to adopt the AMA system of coding and nomenclature as the universal system for description of medical services.

GROUPS WHICH HAVE ADOPTED CPT

State Medical Societies

Medical Association of Alabama
Arizona Medical Association, Inc.
California Medical Association
Colorado Medical Association
Medical Society of District of Columbia
Medical Society of Delaware
Florida Blue Shield Association
Florida Medical Association
Medical Association of Georgia
Illinois Public Welfare Department
Illinois State Medical Society
Kansas Medical Society
Kentucky Medical Association
Louisiana State Medical Society
Medical & Chirurgical Faculty of the State of Maryland
Massachusetts Medical Society
Michigan State Medical Society Council and House of Delegates
Mississippi State Medical Association
Montana Medical Association
Nevada State Medical Association
New Castle County Medical Society, Delaware
Medical Society of County of Monroe, New York
North Carolina Blue Shield
North Carolina Society of Internal Medicine
Ohio State Medical Association
Oklahoma State Medical Society
Oregon Medical Association
Rhode Island Medical Society House of Delegates
Tennessee Medical Association
Board of the Texas Medical Association
Utah State Medical Association
Medical Society of Virginia
Washington State Medical Association
State Medical Society of Wisconsin

Medical Specialties

American Academy of Family Physicians
American Society of Internal Medicine
American Association of Neurological Surgeons
American Academy of Neurology
American College of Obstetricians and Gynecologists
American Academy of Ophthalmology and Otolaryngology
American Association of Ophthalmologists
American Academy of Orthopedic Surgeons
Norwich Orthopaedic Group, Connecticut
College of American Pathologists
American Academy of Pediatrics
American College of Physicians
American Society of Plastic & Reconstructive Surgeons
American Proctologic Society
American Psychiatric Association
American College of Radiology
American Urological Association
Pennsylvania Academy of Ophthalmology and Otolaryngology

Special Groups

Health Insurance Council
World Medical Association

Reference Committees—1971

REFERENCE COMMITTEE NO. 1

Malcolm L. Wrege, Indianapolis (Marion), *Chairman*
Howard R. Marvel, Lafayette (Tippecanoe)
Eric D. Clark, Plainfield (Hendricks)
Charles Egnatz, Schererville (Lake)
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I. E. Michael, Indianapolis (Marion)

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Martin J. O'Neill, Valparaiso (Porter)
Robert Rose, Spencer (Owen-Monroe)
James Fitzpatrick, Portland (Jay)
Carlos M. Ruiz, Boonville (Warrick)

CREDENTIALS COMMITTEE

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Dean K. Stinson, Rochester
T. Neal Petry, Delphi

TELLERS

Robert M. Brown, Marion, *Chairman*
Donald E. Stephens, Indianapolis
Joseph Young, Greenwood
Glen Ward Lee, Richmond

Scientific Exhibits

HOWARD R. MARVEL, M.D., *Lafayette, Chairman*

ISCHEMIC LIMB DISEASE

Exhibitor: Robert L. Dilts, M.D., Indianapolis

Attendant: Robert L. Dilts, M.D.

The purpose of this exhibit is to explain Heart Synchronized Pulse Compression (abbreviate to HSPC) and to demonstrate its effect on ischemic limb disease. HSPC refers to a means of augmenting the systolic blood pressure to provide an added increment of pressure at the small vessel level to open the patent non-functioning micro-vessels of the ischemic tissue. To demonstrate the effect of HSPC augmented pulse amplitude during HSPC. Increased skin perfusion is suggested by elevation of skin temperature and improvement in the color of cyanotic skin. The results of the effects of HSPC on limbs with ischemic disease are demonstrated with color pictures showing progress in cases of diabetic gangrene, ischemic ulcer and occlusive arterial disease.

A UNIVERSITY HEALTH SERVICE

Exhibitor: Student Health Service, Indiana University, Bloomington

Attendant: Professional staff, I.U. Health Center on a rotating basis

The Student Health Service on the Bloomington Campus of Indiana University has programs involving service, education and research. This exhibit reflects some of these programs, demonstrating what can be done to maintain health in a student population through the coordinated use of the resources available. Much of the experience here can be valuable in studying the alternative health care delivery systems.

AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS

Exhibitor: Indiana Society of Medical Assistants

Attendants: Mrs. S. Margaret Rumbaugh, Chairman, and members of Indianapolis Chapter of Medical Assistants

The purpose of the exhibit is to promote interest in our organization and encourage medical assistants to join and participate in diversified, interesting, informative and educational programs to know our profession better. Physician-advisors and local medical societies give their time to assist us with organizational and administrative details. The certification program gives recognition and status to those who earn their CMA initials - an incentive to improve ourselves. AMA and AAMA developed the approval program for college courses in medical assisting. AAMA has an endowment to administer the Scholarship Fund and a Certification Loan Fund.

PEDICLE FLAPS IN RECONSTRUCTIVE SURGERY

Exhibitor: M. Eugene Tardy, Jr., M.D., Department of Otolaryngology, University of Illinois Medical Center, Chicago

Attendants: M. Eugene Tardy, Jr., M.D., and others

The design, construction and successful surgical employment of pedicle flaps in head and neck reconstructive surgery is demonstrated three-dimensionally in this exhibit. Life-size mannequin torsos are employed on individual pedestals to portray approximately fifteen valuable pedicle flaps of proven reconstructive usefulness. The critical blood supply nourishing each regional flap is outlined and demonstrated, emphasizing the unique relationship of blood vessels and skin in the head and neck area.

The steps and considerations utilized in successful employment of pedicle flaps will be further augmented by graphic illustrations and photographs occupying the back panels of the display.

Two back-mounted projectors containing 35 mm slides and super-8 mm short movie strips further portray in ongoing fashion the actual surgical steps both common and unique to the pedicle flaps. Each projector employs four individual earphones for audience audiovisual instruction.

EASTER SEALS IN ACTION

Exhibitor: Indiana Easter Seal Society for Crippled Children & Adults, Inc. Indianapolis

Attendants: James A. Carter and/or Mary Elfers

EASTER SEALS IN ACTION—A FOUR POINT PROGRAM, depicting pictures of crippled children and adults being helped by Easter Seals; offering of pamphlets and brochures to help "tell the story" to the public.

CHEMOSURGERY FOR RECURRENT AND INVASIVE CANCER OF THE SKIN

Exhibitor: Barry A. Goldsmith, M.D. Chicago

Co-exhibitor: Milton W. Eisenstein, M.D. Chicago

Attendant:

Recurrent cancer of the skin and a few other well-defined categories of skin cancers are difficult to treat with conventional therapy (i.e. surgery or radiation). Chemosurgery is a newer form of surgical treatment based on systematic surgical excision of previously chemically fixed tissue with microscopic control of the entire specimen removed. It has been shown to be more effective in dealing with these problem cases with conservation of remaining tissue and safety to the patient.

CONTINUING MEDICAL EDUCATION IN INDIANA

Exhibitor: Indiana University School of Medicine, Medical Education Resources, Indianapolis

Attendants: Mr. Seldon Bradley and Mr. Paul Neel

A display diagramming the Indiana University School of Medicine system of originating and distributing medical education programs and materials throughout the state of Indiana.

SOME PROBLEMS OF DISLOCATIONS

Exhibitor: Indiana Bone and Joint Club
South Bend

Co-exhibitor: Department of Medical Education
St. Joseph's Hospital
South Bend

Attendants: Members of Indiana Bone and Joint Club and Department of Medical Education of St. Joseph's Hospital

The problems of some dislocations occur at the time of the initial reduction. Some are difficult to reduce, some are difficult to maintain, and in some it is difficult to know that accurate reduction has been obtained. Others are difficult to diagnose and are frequently missed. Other dislocations are frequently associated with complications.

This exhibit has been prepared by the Department of Medical Education at St. Joseph's Hospital in South Bend to demonstrate some of these problems, and their management, under the auspicies of the Indiana Bone and Joint Club.

EPICONDYLITIS OF THE ELBOW

Exhibitors: Leslie M. Bodnar, M.D.; Z. W. Zobol, M.D.; M. L. Troyer, M.D.; David Krizman, M.D., and Jack Sherer, M.D., South Bend

Attendants: Leslie M. Bodnar, M.D.
Z. W. Zobol, M.D.
Marlin L. Troyer, M.D.
Dave Krizman, M.D.
Jack Scherer, M.D.
Gerald M. Cullen, M.D.

Medial or lateral epicondylitis may result from indirect injury in athletics. There is remarkable similarity in the action of the elbow and arm in hitting and throwing, in various sports. The initial wind-up, rotation of the body away from the target, the adduction and external rotation and hyper-extension of the shoulder, are similar in most sports. The propulsive phase in which the body is whipped around to start the forward action, with the elbow in a flexed position, wrists firm and hand closed, advancing the shoulder, then the elbow and then the hand, are also similar in most sports. The dissimilarity in sports occurs at the moment of release of the object or at the moment of the impact against an object. In the throwing actions, valgus strain occurs on the elbow as the arm is brought forward with the elbow leading the hand. At that moment the finger flexors suddenly relax and the wrist flexors snap to propel the ball, javelin, etc. Therefore, these strains are more likely to cause medial epicondylitis in throwers as well as in other athletes who maintain the open hand, such as handball players, etc. In the hitting action, the hand remains closed, maintaining tension on the finger flexors, stablizing the elbow against the valgus strain, but promoting a varus strain in the follow-through phase in which the arm is carried across the body. Because of this varus strain, hitters such as tennis players, golfers, etc., are more likely to suffer lateral epicondylitis. The exhibit demonstrates the similarity in action of some of the hitting sports and of some of the throwing sports actions, and a movie further demonstrates these mechanisms.

COPULATION AND OVULATION

Exhibitor: James H. Clark, Ph.D., Department of Biological Sciences, Purdue University, Lafayette

Attendant: James H. Clark, Ph.D.

The purpose of this exhibit is to present evidence that copulatory induced ovulation occurs in women. Results from work done with rats will show that copulatory stimuli do induce ovulation in animals which normally ovulate spontaneously. Thus the capacity for copulatory induced ovulation is present in a spontaneous ovulator. Evolutionary considerations will be presented to show that animals, including the primates and man, which are usually considered to be spontaneous ovulators, may also retain the capacity for copulatory induced ovulation.

A reapprasial of the evidence for spontaneous ovulation in women will be presented which indicates a strong likelihood that copulatory induced ovulation occurs in some women. Evidence from the literature concerning rape and pregnancy will demonstrate clearly that copulation can induce ovulation in women during any phase of the menstrual cycle.

PHYSICIAN'S TIME SAVER MATERIALS

Exhibitor: Indiana Heart Association, Indianapolis

Attendants: David E. Livengood, Frederic H. Weigle, Jan I. Koontz, Richard A. Smith and William A. Dudley

The exhibit proposed is designed around American Heart Association and Indiana Heart Association lay educational materials. These materials were selected by the Medical Education Committee of the Indiana Heart Association from materials identified as having saved them time in caring for their patients.

The materials to be exhibited will be patient-oriented and designed to answer the patients' questions on hypertension, heart attack, atherosclerosis, angina, and stroke.

THERAPY OF PELVIC INFECTIONS WITH CEPHALOSPORINS

Exhibitor: N. J. Thompson, M.D., Dayton, Ohio

Co-Exhibitors: John K. Heuntelman, M.D.,
C. Roger Moritz, M.D.
R. Alan Baker, M.D.
William Stalter, M.D.

The exhibit is a study of 100 patients with salpingitis and septic abortion who were treated with a regimen of cephalothin and cephaloridine. All received cephalothin I.V. until afebrile; 86% became afebrile in 6 days. Following this regimen 25 received cephalothin I.M. and 75 cephaloridine I.M. until dismissal. No allergenic reactions occurred. Fifty-nine of 61 salpingitis patients (N. gonorrhoeae was isolated from 29) and 36 of 39 septic abortion patients, i.e., a total of 95%, responded satisfactorily to cephalosporin therapy.

MARIHUANA AND ITS TOXICOLOGY

Exhibitor: Robert Martz, M.D., Department of Toxicology, Indiana University School of Medicine, Indianapolis

Co-exhibitors: Robert B. Forney, Ph.D.
Daniel J. Brown, Ph.D.

Attendants: Robert Martz, M.D., and Daniel J. Brown, Ph.D.

Of the psychoactive drugs in use today, probably the most controversial is marihuana. The purpose of this exhibit is to demonstrate the plant material itself and the toxicology of marihuana.

CANCER PREVENTION STUDY

Exhibitor: American Cancer Society, Indiana Division, Indianapolis

Attendant: Mr. Frank Unum, Indianapolis

The Cancer Prevention Study was conducted by the American Cancer Society over a five-year period of time concluding in 1964 from which the Surgeon General's Report on Smoking and Health was written. The exhibit will do two things. One, it will outline the past Cancer Prevention Study and what it accomplished. Two, it will set the way for an upcoming Cancer Prevention Study to be started in October of 1972.

EPIDERMAL DYNAMICS

Exhibitor: Allan A. Katzberg, Department of Anatomy, Indiana University — Purdue University Indianapolis

Attendant:

The human epidermis undergoes a series of morphological changes from birth to old age. These include a reduction in thickness, involution of the rete pattern, reduction in area of the epidermo-dermal junction. Physiologically this is accompanied by a shift in the regenerative capability from the spinous to the basal layer, an increase in the mitotic index, an increase in chromosomal aneuploidy, and a reduction in the life span. Nourishment of the epidermis is reduced by involution of the vascular rete in the dermis.

After the epidermis leaves the very constant environment of intra-uterine life and is exposed to the elements, it is subjected to a greater variety of environmental stress factors than any other tissue of the body. The effect of these factors is compounded by the introduction of a whole new spectrum of irritant and exotic contaminants that are by-products of our advanced civilization. The epidermal cells respond with an attempt at accommodation by an altered morphology and dynamics. Failure to do so may introduce potential pathological processes.

DIVERSIFIED MANAGEMENT OF PREGNANCY

Exhibitor: Suemma Coleman Home, Indianapolis

Attendants: Floyd R. Elliott, Miss Marie Wetzel, Mrs. Elizabeth Hughes, Mrs. Judith Murphy and Mrs. Emily T. Wiggs

Suemma Coleman Home of Indianapolis has served the unwed mother for more than 75 years and continues to improve and broaden the skills toward helping the girl, the couple and their families. A team approach has been used by the social service department, the medical staff and the community resources.

The professional social service staff of Suemma Coleman Home, through its counseling service, offers an opportunity for those involved to evaluate their situation more objectively. The various avenues of management of a pregnancy are shared and the individual must decide on the most appropriate pathway—whether it be marriage, maternity home care, a legalized abortion, stay at home—and whether she will retain or release her child.

A Home resident will find caseworkers, an obstetrician, nurses and a consulting phychiatrist. Regular programs include group therapy, individual counseling, big-sister nursing, volunteer work in local hospitals, job opportunities, continuing education and recreation. Family counseling is also a needed resource. If a girl seeks help as an outpatient, she, too, will receive counseling and can participate in many of the programs offered the residents. If a girl releases her child for adoption, the Suemma Coleman Home can help her as a legal child placement agency.

IAGP MEMBERSHIP BOOTH

Exhibitor: Indiana Academy of General Practice, Indianapolis

Attendants: Mrs. Jackie Schilling, Mrs. Jackie Stahl and Jean Hinchman, M.D.

The Indiana Academy of General Practice membership and organizational exhibit pictures the functions of the Academy relative to the governing body, committee structure and activities.

Membership material will be available for distribution. One prerequisite for membership in the Academy is membership in the Indiana State Medical Association and local county medical society.

VEIN GRAFT SURGERY FOR CORONARY ARTERY DISEASE

Exhibitor: Siderys-Pittman Medical Corp. Indianapolis

Co-exhibitor: Harry Siderys, M.D., John Pittman, M.D., Gilbert Herod, M.D., and Harry King, M.D.

Attendants: Harry Siderys, M.D., and Pamela Linder

The surgical treatment of coronary artery disease has made rapid advances in the past three years. Prior to this time, the evolution of surgical therapy was slow and results equivocal.

Attempts at direct reconstruction of diseased coronary arteries have met with disappointing results. Longmire and associates, whose experience spanned ten years, performed coronary artery endarterectomies in 25 patients. In most cases, this procedure was used to clear the right coronary artery, but the incidence of postoperative occlusion was high.

Patch angioplasty and vein graft interposition were an improvement over thromboendarterectomy, but these procedures were associated with a high incidence of stenosis or thrombosis. When applied to branches of the left coronary artery, these techniques carried a prohibitive mortality.

The aortic to coronary artery bypass operation, utilizing the saphenous vein, appeared on the scene in 1967, popularized by Dudley Johnson and Rene Favaloro. The success of this surgical procedure can be ascribed to the fact that arteriosclerosis of the coronary arteries is limited to the proximal few centimeters and almost never involves coronary arteries less than two millimeters in diameter.

OSTEOPOROSIS: WILL YOU GET IT?

Exhibitor: David McMullen Smith, M.D., Indiana University Medical Center, Indianapolis

Co-exhibitor: C. C. Johnston, M.D.

Attendants: John Thompson and David M. Smith, M.D., Sue Rahhell.

Postmenopausal osteoporosis is characterized by a decrease in skeletal mass and an increase in fracture rate. Those who develop the disease may have an abnormally low skeletal mass at maturity, may lose mass at an accelerated rate, or both. Studies in 524 Caucasian females using the photon absorption technique for measuring bone mass in the radius, showed an increased rate of loss of bone in all women beginning between age 40 and 50, but the variability within the population did not increase and the distribution of bone mass in the population remained normal. Those women with vertebral fractures appeared to be losing mass at the same rate as those without fracture, but their age-corrected mean bone mass was lower. These data are most compatible with the thesis that osteoporosis occurs in those individuals in the population who have a lower bone mass at maturity.

This exhibit shows the results of the above studies. Bone mass measurements will be done on volunteer viewers of the exhibit and comparison of the measurements will be made with those of a normal age-matched population.

INDIANA EMERGENCY MEDICAL SERVICES

Exhibitor: Indiana State Board of Health, Indianapolis, Indiana

Attendants: Charles R. Hudson and Robert K. Mills

Accidents and other emergencies are the fourth leading cause of death in the United States today. Statistics are now indicating that a considerable number of people lose their lives because of inadequate or improper emergency care.

This will be an educational display which will utilize a series of charts, posters, photographs and other educational material to illustrate the importance of and need for the development of an emergency care system which will provide quick identification and response to emergency situations, and which will sustain and prolong life through proper first aid measures at the scene and in transit, and which will assure that no victim of an emergency situation in the State of Indiana is more than fifteen minutes away from top quality medical and hospital care and can be transported to this care without simultaneously creating additional hazards.

MEDICINE AND RELIGION

Exhibitor: American Medical Association, Department of Medicine and Religion Chicago, Ill.

Attendant:

This is a display with materials furnished for the use of the ISMA Committee on Medicine and Religion.

Materials furnished express the philosophy and objectives of the AMA Department of Medicine and Religion and give ideas for county society committees on Medicine and Religion.

The most important feature of this booth is the opportunity offered to physicians of Indiana to discuss the philosophy of the ISMA Committee on Medicine and Religion with representatives of the committee.

Specifically, materials will include samples of programs on drugs, crisis counseling, and efforts in the treatment between the physician and the clergy.

HEALTH FORECAST IN PROSPECTIVE MEDICINE

Exhibitor: Lewis C. Robbins, M.D., Methodist Hospital, Indianapolis

Co-Exhibitors: Robert Acher, M.D., Ronald Blankenbaker, M.D., Fred Brooks, M.D., Kenneth Gray, M.D., and Jack H. Hall, M.D.

Attendants: Susan Young, Amy Gilligan and Nancy Gilbert

Prospective medicine which practices health maintenance needs visibility. In the Annual Patient Review, Edward Kowalewski has pointed to the need for a quick means to inform the patient of his top risks, and preventive procedures to reduce these risks. This visibility is provided in the "Bar Chart" or health forecast. Physicians will be given the material to perform Annual Patient Reviews and shown how to interpret the simple bar chart to their patients.

PROCUREMENT AND DISTRIBUTION OF CADAVER KIDNEYS FOR TRANSPLANTATION

Exhibitor: James A. Madura, M.D., Department of Surgery, Indiana University Medical Center, Indianapolis

Co-Exhibitors: John Donohue, M.D. John Glover, M.D.

Attendant: James A. Madura, M.D.

This exhibit is presented by the Indiana University Medical Center Transplant Committee to demonstrate the procedures involved in attempting to insure well-matched kidneys for patients suffering from end-stage renal disease in Indiana as well as other cooperating medical centers in Southeastern United States.

The course of events leading to selection of patients as donors, and the process of lymphocyte typing and subsequent computer search for the best donor-recipient pair are explained. The Belzer organ perfusion apparatus is shown, which can maintain kidneys in a viable state until the tissue typing is done and the selected recipient is ready for implantation of the kidney.

In addition, the various modes of transportation of organs, both inside the state and around the country, as well as up-to-date results of the kidney-sharing program are presented. Information for physicians will be available to include: (1) donor card information for persons wishing to donate organs under the Anatomical Gift Act; and (2) instructions to physicians and hospitals on the exact procedures to follow when a donor becomes available.

It is hoped that the importance of the cadaver kidney program will be realized and that interested individuals will be stimulated to participate in this activity.

PERCUTANEOUS REMOVAL OF INTRAVASCULAR FOREIGN BODIES

Exhibitor: Roscoe E. Miller, M.D., Department of Radiology, Indiana University Medical Center, Indianapolis

Co-exhibitor: Edward M. Cockerill, M.D.

Attendants: Roscoe E. Miller, M.D., and Edward M. Cockerill, M.D.

The intravascular snare technique is a simple benign non-operative approach for the removal of catheter emboli replacing the need for thoracotomy.

The widespread use of polyethylene tubing for continuous intravenous infusions and central venous pressure monitoring continues to grow. Catheter embolization is one of the more serious of the increasingly frequent complications resulting from the use of these devices. The majority of these emboli quickly escape the extremity and lodge in the central cavae, right heart or pulmonary artery.

A percutaneous intravascular snare technique for the removal of these emboli is demonstrated using a small, doubled guide wire for a snare. Successful removal of a polyethylene catheter may be accomplished without phlebotomy with uncomplicated angiographic catheter techniques.

come together!

To the 25th AMA Clinical Convention in New Orleans. Participation will be the key at this medical meeting -- you and your colleagues getting together for a useful and rewarding learning experience. Evaluating and discussing the problems of clinical medicine.

The scientific program is outstanding, with three in-depth postgraduate courses on Behavioral Problems in Children and Adolescents; Cardiovascular Disease; and Fluid and Electrolyte Balance. Other sessions you'll want to attend include Diagnostic Evaluation and Management of Joint Diseases; Dermatological Problems in Everyday Practice; Current Concepts in Gastroenterology; Office Gynecology: Management of Common Problems, and a Symposium on Diverticular Disease of the Colon. Along with these sessions are dozens of scientific and industrial exhibits to help inform you of the latest research and the newest products and services.

Plan to be there. See the complete scientific program and registration forms in the October 18th issue of JAMA.

25th
AMA Clinical Convention
November 28 - December 1, 1971
the Rivergate
Convention Center
New Orleans



Art, Hobby Show Planned For ISMA Annual Meeting

Space will be provided at the 1971 annual meeting of the Indiana State Medical Association, October 12, 13 and 14, at Indianapolis for a Physicians' Art and Hobby Show.

The Woman's Auxiliary of the Indiana State Medical Association has been invited to participate in the show.

Members of ISMA interested in exhibiting pieces and requiring any information regarding this can contact:

Indiana State Medical Association
3935 North Meridian Street
Indianapolis, Indiana 46208

It will be the responsibility of each physician to see that his work gets to the exhibition at the Murat Temple, Indianapolis. Final arrangements will be taken care of by a committee.

The ISMA will provide suitable display facilities, but each physician is responsible for transportation costs and any other such expenses involved in entering his exhibit.

We solicit your exhibit to make this the largest and best ever this year.

Application for Space in Art and Hobby Show Exhibit

Mail to:

Indiana State Medical Association

3935 North Meridian Street

Indianapolis, Indiana 46208

Name_____

Address_____

City_____

Type and number of pieces to be displayed: _____

Photography_____

Sculpture_____

Crafts_____

Painting_____

Other_____

Estimated amount of space required—lineal or square feet _____

Other information_____

_____



Additional information available to the profession on request.
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Robinul® 2mg. Forte (glycopyrrolate)

NDICATIONS Robinul Forte (glycopyrrolate, 2 mg.) and Robinul-PH Forte are double-strength dosage forms of glycopyrrolate. They are primarily icated for patients who are less responsive to anticholinergic therapy and for control of the more prominent symptomatology associated with te episodes of gastrointestinal disorders. Emphasis should be on total management, with due consideration of the various therapeutic modalities ilable, including diet, antacids, anticholinergic agents, sedatives, and attention to emotional problems. Accordingly, glycopyrrolate is recommended in the management of gastrointestinal disorders amenable to anticholinergic therapy, such as: (1) duodenal ulcer, duodenitis, pylorospasm; gastric ulcer, gastritis, esophageal hiatal hernia, hyperchlorhydria, pyrosis, aerophagia, gastroenteritis; (3) esophagitis; (4) cholecystitis, chronic ncreatitis; (5) spastic and irritable colon, ulcerative colitis, functional bowel distress, diverticulitis, acute enteritis, diarrhea; and (6) splenic flexure ndrome, neurogenic gastrointestinal disturbances. When these conditions are associated with psychic overlay, the formulation with phenobarbital y be indicated. ■ CONTRAINDICATIONS Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH te (glycopyrrolate with phenobarbital), sensitivity to phenobarbital. ■ PRECAUTIONS Administer with caution in the presence of incipient ucoma. ■ SIDE EFFECTS The most frequent side effect noted during clinical trials was dry mouth. Thirty-three (3.3%) of 1,009 patients receiving o 32 mg. of glycopyrrolate a day complained of dry mouth of moderate to severe degree, but only 11 discontinued treatment because of this. rred vision, constipation, and urinary hesitancy have been reported infrequently. Other side effects associated with the use of anticholinergic gs include: tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash. ■ DOSAGE The average and maximum recommended dose of Robinul Forte (glycopyrrolate, 2 mg.) or Robinul-PH Forte is one let three times daily (in the morning, early afternoon, and at bedtime). To obtain optimum results, dosage should be adjusted to the individual ient's response. After the more severe symptoms associated with acute conditions have subsided, the dose may be reduced to the minimum uired to maintain symptomatic relief. ■ SUPPLY Robinul Forte (glycopyrrolate, 2 mg.) is available as scored, compressed pink tablets engraved R/2 in bottles of 100 and 500. ■ Robinul-PH Forte (glycopyrrolate, 2 mg., with phenobarbital, 16.2 mg.) is available as scored, compressed blue lets engraved AHR/2 in bottles of 100 and 500.

A. H. Robins Company, Richmond, Va. A·H·ROBINS


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The Development of a Voluntary Rural Emergency Ambulance Service

ROBERT B. STONEHILL, M.D.
Zionsville*

MANY smaller communities without local hospitals have a problem dealing with medical emergencies. Zionsville, Indiana, a town of 2800 people, resolved this problem through the efforts of public spirited citizens. Zionsville is a town with pride, having completed restoration of its business district into a colonial motif. It has three practicing physicians and its share of accidents. What was needed was an effective, available emergency ambulance service to transport emergencies to the hospital at Lebanon, 17 miles away, or to one of the Indianapolis hospitals, about the same distance.

Project Initiation

A group of public spirited citizens, under the sponsorship of Boone County civil defense group, conducted a campaign to develop this capacity. Within a year public subscription obtained more than $9,000 to purchase and equip a modern and efficient ambulance. A new Ford Windovan truck, which resembles a large sturdy delivery truck, was specially outfitted by Rescue Incorporated of Shelbyville so that oxygen and suction equipment as well as cabinets and stretcher space were installed. This vehicle also had flashing lights, siren and radio equipment. It was fully stocked with medical supplies fulfilling the recommendations of the American College of Surgeons.

* Professor of Medicine, Indiana University School of Medicine.

Trainees

A group of 14 volunteers, of which I was one, underwent an intensive training program in first aid and ambulance procedures. A good proportion of these volunteers were women. This course was given in our Town Hall two hours each Sunday by members of the trauma section of Marion County General Hospital. We had 16 hours of initial training and refresher training continues monthly.

Organization

The group incorporated into a nonprofit organization and elected a board of governors of seven members who selected one member as president. Dr. Harvey Lovett, a local general practitioner, became our medical director. We established two monthly meetings: a general membership meeting on the second Tuesday and a board of governors meeting on the fourth Tuesday. Various committees were formed—such as supplies and equipment committee, the communications committee and the training committee. Thus, we were assured of a functional operation.

Finances

We were in need of operational funding and a building to house our operation. About this time the Indiana Bell Telephone Company closed its Zionsville office. Largely through the efforts of Dr. Charles Rushmore, medical director of Indiana Bell, we obtained permission to rent the building for our ambulance, storage space, an office to house our radio equipment and a large meeting or classroom.

We applied to the Eli Lilly Foundation for operational funding until we would be able to obtain support from the community and surrounding townships which we would serve. They very kindly honored our request and we became operational at the beginning of 1970. Since then we have received funds from both Eagle and Union Township Trustees. In addition, voluntary donations are still accepted and have continued to be contributed from such organizations as the local American Legion Post, local fraternal organizations and sororities.

No payment is necessary to utilize our service for medical emergencies. Since many patients carry insurance policies which pay for such services we do send a statement after a run to help patients apply for insurance payments. These charges are currently $30 a run.

Operation

As a matter of operational policy, we are an emergency service. We do not perform routine transportation functions. Our local funeral home can still perform this function. Thus we answer calls only from local physicians, the Fire Department and the Police Departments, including the Zionsville Police, the Boone County Sheriff and the Indiana State Police. These parties call our emergency number which rings five phones in homes of our dispatchers. The dis-







patchers arrange coverage among them. When the dispatcher receives a call, he or she refers to the on-call roster and calls out the crew from their homes. Each crew consists of 4 ambulance technicians. The first three to arrive at the office take out the ambulance and the fourth mans the radio there to keep up communication with the ambulance. Our response time is 15 minutes or less.

Fire Department

We have another advantage. The Zionsville Volunteer Fire Department has had a small emergency vehicle which is equipped with some first aid equipment, metal saws, power jacks and oxygen. Members of the Fire Department respond to a siren and can move out their vehicle within five minutes. Thus, often in the case of an accident, the Fire Department is on the scene initiating first aid when we arrive with the ambulance. We then assume responsibility, complete first aid, and transport the patients to the hospital. We radio back to our office the number and type of casualties and the hospital to which we are proceeding. This information is then relayed by telephone to the hospital so that its emergency room is ready to receive us. We have had excellent cooperation from all hospitals. In 1970 we made 112 runs.

On-Call System

Our on-call system is very important. We have four technicians on call at all times: 24 hours a day, 7 days a week. The day is divided into 12 hour shifts starting at 6:00 a.m. and 6:00 p.m. Here is where our ladies are most important. They are available on days during the week while the men generally cover at night and during the weekends. It is not unusual for an all female crew to make a run during weekdays.

Expansion of Membership

Since initiation, we have expanded from 14 to 27 ambulance technicians. We now do our own training. Five of our members have become qualified Red Cross first aid instructors.

Type of Person

What type of person has joined our group? It is a heterogeneous mixture. To mention a few, we have housewives, a mailman, an Eli Lilly executive, a barber, a professor of medicine, a watchman, nurses and a salesman. The common denominator is a sense of mission and therefore a common purpose.

Community Response

Our community has become proud of us. Our ambulance was in the last Zionsville Fall Festival parade. The local newspaper has given us excellent support initially during the drive for funds and now in coverage of our activities. Our local physicians call upon us regularly. We now have an excellent emergency ambulance service which involves our own people. The service has already saved some lives and helped relieve a great deal of suffering.

Model for Other Communities

However, what is also of importance is that we believe that we have developed a model that other rural communities can copy and thus expand this type of capability throughout the State. This type of expansion would be in accord with the recommendations of the Governor's Commission on Emergency Medical Services.

There were several ingredients which made this a successful venture. There was the recognition of a well defined need. There was a nucleus of non-professional citizens who took the initiative and started the drive for public subscriptions. There was a generous response from the public who also saw the need. There was counsel taken with the local practicing physicians and the prospective receiving hospitals. Finally, there was determination and eternal hope. Once the movement started, it gained momentum and finally pride in accomplishment became a factor. ◄

New Professional Liability Insurance Program Announced by AMA

Remarks by Dr. Carl Hoffman, President-Elect of the American Medical Association, July 26, 1971

THIS is, for me, a very satisfying occasion. As chairman of the AMA's Committee on Professional Liability, I have been personally concerned and involved in efforts to find solutions to a problem which—if it were a disease—would now be considered to be of epidemic proportion.

I am speaking of physician professional liability insurance suits — more commonly known as malpractice suits. It is a matter of deep concern to doctors, obviously, and to insurance companies. And, although the public does not generally recognize it, it is a problem that has considerable impact on it as well.

The seriousness of the problem is best pointed up, I believe, by the fact that President Nixon has deemed it important enough to establish a Presidential Commission on Medical Malpractice and to cite it in his Health Care message as one of the problems we must resolve.

The fact is that medical malpractice claims have risen nearly 50 per cent over the past five years. These claims are increasing at a rate higher than the general inflation in our national economy. Obviously, when doctors have to pay more for insurance and insurance companies have to pay more in claims and defending against claims, these added costs are passed back to the consumers of health care and insurance — and that, of course, means just about everybody.

So severe has the problem become, in fact, that there are now some states where professional liability insurance is unavailable to certain types of physicians. The program we are unveiling here today is in part an answer to that problem. Working in cooperation with CNA insurance and Marsh and McLennan, the AMA is now in a position to offer — through state and county medical societies — a comprehensive program of professional liability insurance to doctors in states that are left largely uncovered.

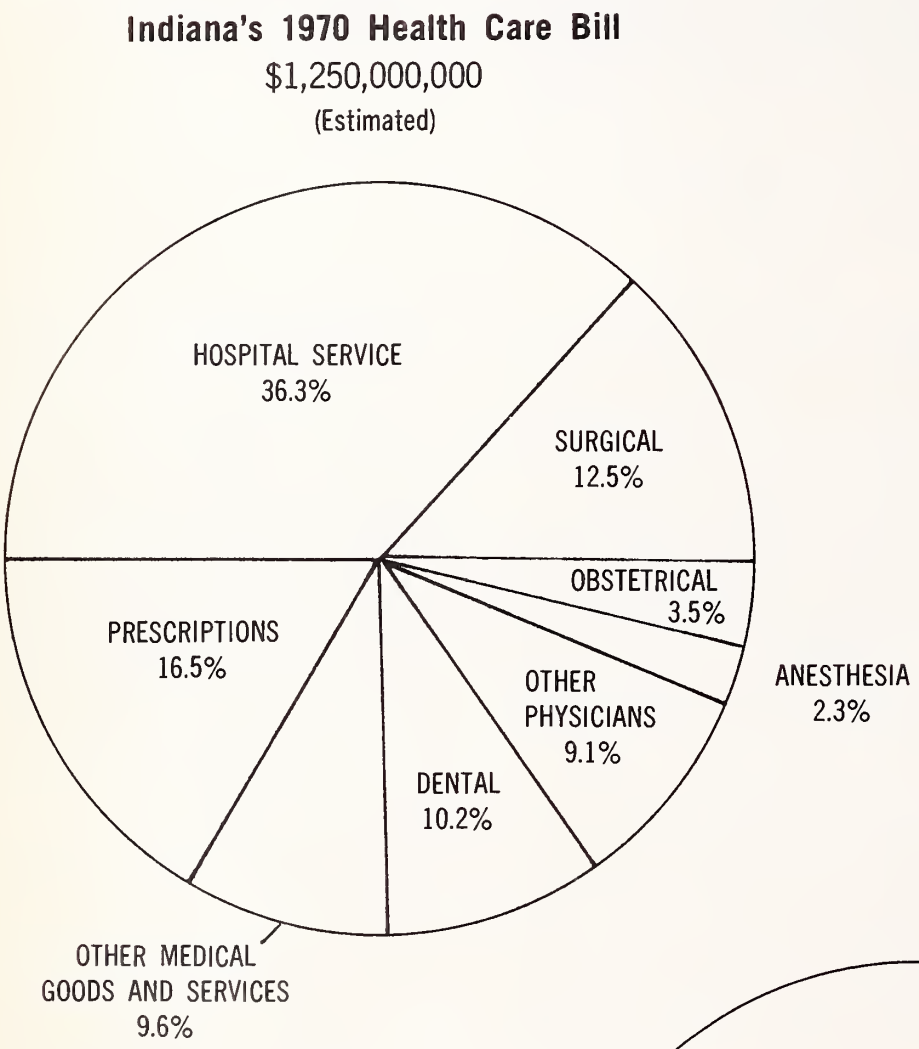
But even more, this program represents a new approach to the problem — a new concept of insurance that -- rather than merely reliving the symptoms — makes a concerted effort to remedy some of the causes. This is a very important advance in our approach to the problem. And I do not think I am exaggerating, therefore, when I say that this program represents a true breakthrough.

But no insurance program — no matter how imaginative or comprehensive — will of itself resolve the overall problem. To do that, we need to continue to seek legislative relief and—even more important—we need to attack the problem at its roots, to eliminate or at least reduce the incidents that lead to malpractice suits. Thus, this past May the AMA joined with the American Hospital Association to sponsor a National Conference on Patient Safety in the Hospital to seek ways to improve patient protection techniques in our hospitals. For it is in hospitals that a very large percentage of the incidents occur that lead to malpractice suits.

I cite these to show that we are thinking in terms of a total attack on the problem. A very important part of that attack is the insurance program we are announcing here today. It is a program that breaks new ground — that is responsible to doctors, to the insurers and to the public interest.

We at the AMA are proud and pleased to have played a role in its formulation and to be able to offer it as a service to our constituency. I wish to thank and congratulate both CNA insurance and Marsh and McLennan for their understanding approach to the problem and for their cooperation in devising a program to meet it. ◄

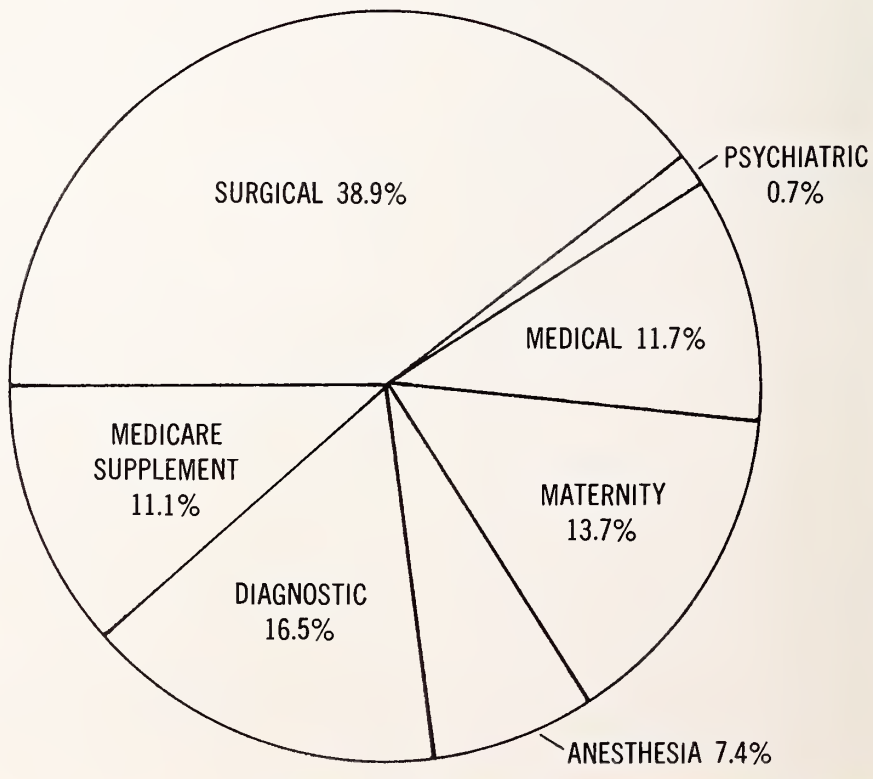
Charting the Indiana Health Care Dollar



The chart at the upper left represents the estimated distribution of the 1970 Indiana health care bill, and the one at the lower right shows the percentage division of the 1970 Indiana Blue Shield dollar.

Hospital service took the biggest slice of last year's estimated Indiana health care bill, with approximately 36.3%, or $453,750,000 of the total amount. The distribution is based on a total figure of $1,250,000,000. Prescriptions claimed the next largest portion with a percent of 16.5 and an estimated expense of $206,250,000.

The 1970 Indiana Blue Shield dollar distribution shows 38.9% of the bill going for surgical, while diagnostic is the second largest payment with a 16.5% figure. Surgical payments amounted to $19,736,702.30 while diagnostics were $8,378,504.28 of the overall figure of $50,702,718.23.



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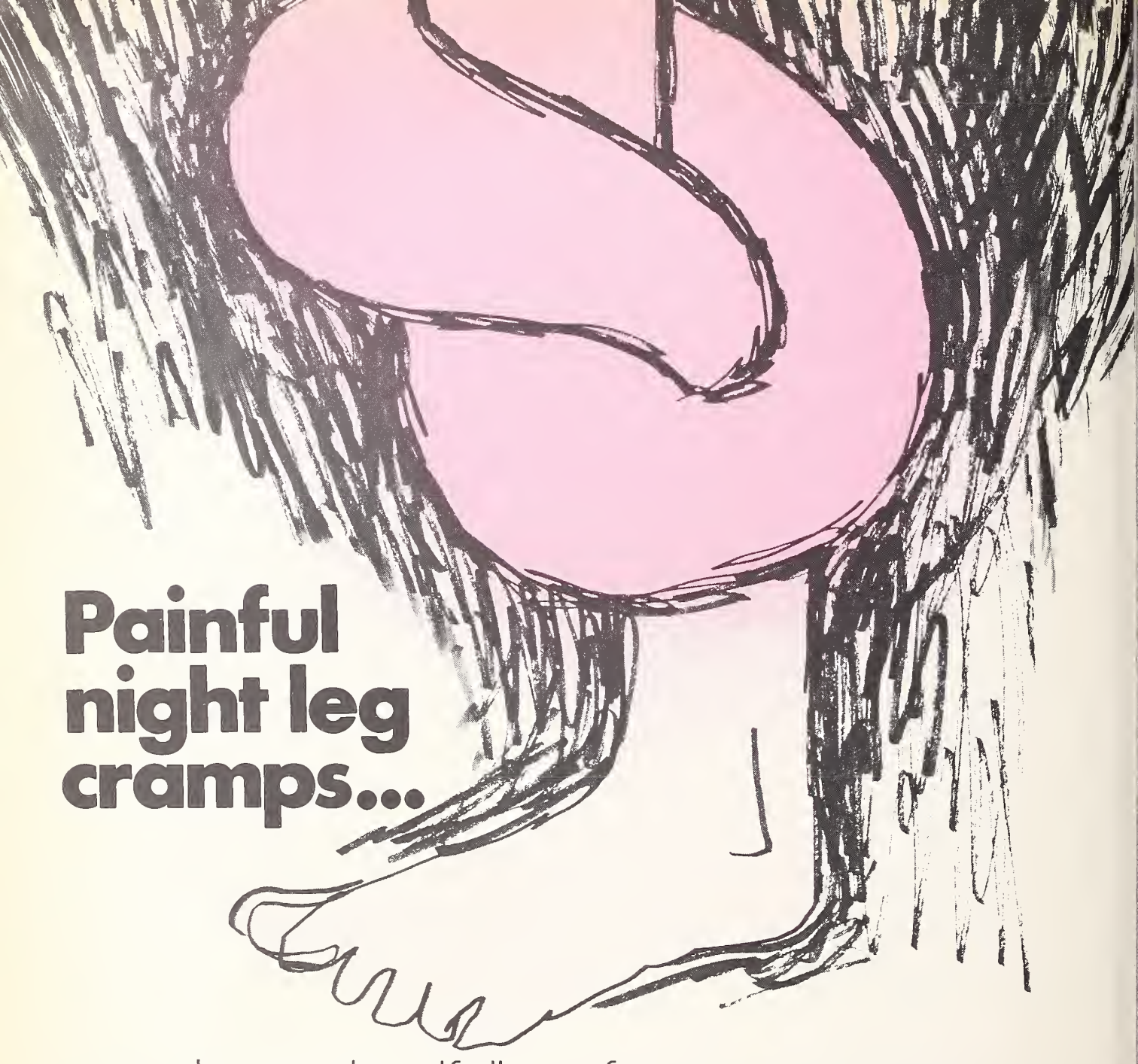
Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause *CNS effects* such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. *Sympathomimetic cardiovascular effects* reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. *Allergic phenamena* reported include such conditions as rash, urticaria, ecchymosis, and erythema. *Gastrointestinal effects* such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

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Licensed Nursing Homes In Indiana

July 1, 1971 Supplement To

Indiana Licensed Health Facilities Directory published January 1, 1971

ALLEN COUNTY

Turtle Creek Convalescent Centre of Fort Wayne South, Inc.
2626 Fairfield Avenue, Fort Wayne 46807
Gary D. Neterer, Adm.

BARTHOLOMEW COUNTY

National Nursing Home of Columbus
5400 East 25th Street, Columbus
Rosie Marie Robold, R.N., Adm.

BENTON COUNTY

"Edge-Wood View"
Oxford 47971
Rosemary Eddy, Adm.

Green-Hill Manor, Inc.
501 North Lincoln Avenue, Fowler 47944
Edith Dexter, R.N. & Connie Brouillette, R.N., Adms.

CLINTON COUNTY

Milner Community Health-Care, Inc.
Box 15, Rossville 46065
Robert E. Hine, Adm.

DAVIESS COUNTY

Bertha D. Garten Ketcham Memorial Center, Inc.
601 East Race Street, Odon 47562
Irven D. Myers, Adm.

DECATUR COUNTY

Greensburg Hospitality Nursing Center Inc.
410 Park Road, Greensburg 47240
Chester O'Neal, Jr., Adm.

DELAWARE COUNTY

Golden Rule Nursing Home
502 North Madison Street, Gaston 47342
James Nash, Adm.

ELKHART COUNTY

National Nursing Home of Goshen
1101 West Lincoln Avenue, Goshen 46526
Betty Lee Nei, R.N., Adm.

HARRISON COUNTY

National Nursing Home of Corydon
400 East High School Rd., R. R. #4, Corydon 47112
Mary A. Bass, L.P.N., Adm.

HENRY COUNTY

Resthaven
420 South Main Street, New Castle 47362
Elizabeth Griggs, L.P.N., Adm.

JAY COUNTY

Country Manor Nursing Home, Inc.
Route #2, Dunkirk 47336
Janellyn Antrim, R.N., Adm.

JENNINGS COUNTY

National Nursing Home of North Vernon
801 North Elm Street, North Vernon 47265
Nora Carlene Bliton, L.P.N., Adm.

LAKE COUNTY

Hammond-Whiting Convalescent Center
1000 - 114th Street, Whiting 46394
Geraldine Wiseley, Adm.

MARION COUNTY

The Alpha Home
1910 N. Senate Avenue, Indianapolis 46202
Emarita Murphy, Adm.

T. Wray Nursing Home
1812 Central, Indianapolis 46202
Thelma F. Wray, L.P.N. & Mollie Hensly, Adms.

MONTGOMERY COUNTY

Massengill's Retirement Home
1304 South Grant Ave., Crawfordsville 47933
Raymond & Joan Massengill, Adms.

NEWTON COUNTY

National Nursing Home of Kentland
720 East Washington St., Kentland 47591
Joan R. Zeitlin, R.N., Adm.

PULASKI COUNTY

National Nursing Home of Winamac
515 East 13th Street, Winamac 46996
Mary Colleen Drews, R.N., Adm.

ST. JOSEPH COUNTY

Essex Nursing Home
1106 S. 20th St., South Bend 46615
Hugh O. Erickson, Adm.

The Robert P. and Clara I. Milton Home, Inc.
206 E. Marion St., South Bend 46601
Mrs. T. E. Mauch, Adm.

SPENCER COUNTY

Spencer County Home
R. R. #1, Rockport 47635
James T. Vaughn, Adm.

STARKE COUNTY

The Shepherd's Inn
300 East Culver Road, Knox 46534
Larry DePue, Adm.

STEUBEN COUNTY

Carlin Park Nursing Home, Inc.
North Williams Street, Angola 46703
Flo Sheehy, Adm.

TIPTON COUNTY

National Nursing Home of Tipton
701 E. Jefferson Street, Tipton 46072
Marcia Ellen DeWitt, R.N., Adm.

VERMILLION COUNTY

National Nursing Home of Clinton
700 South Main St., Clinton 47842
Nancy Robinson, R.N., Act. Adm.

WAYNE COUNTY

Golden Rule Nursing Home, Inc.
2001 U.S. 27, South, Richmond 47374
Betty Montgomery, L.P.N., Adm.

WELLS COUNTY

South View Rest Home, Inc.
R. R. #3, Box 306, Bluffton 46714
Cora N. Anderson, L.P.N. & Karl Anderson, Adms.

WHITE COUNTY

Lake View Home (White County Home)
R. R. #6, Monticello 47960
Ora Rumple, Adm.

CHANGE IN NAME AND/OR OWNERSHIP

HENRY COUNTY

New Castle Community Care Center
(Formerly "The Boxwoods" Nursing Home)
115 North 10th Street, New Castle 47362
Lula M. Haynes, L.P.N., Adm.

LAPORTE COUNTY

Private Home Care (Country Division)
(Formerly Stites Home, Inc.)
State Road 39, North, LaPorte 46350
Roger J. Schofield, Adm.

MADISON COUNTY

The Goble Home
(Formerly Goble Home)
332 West 11th St., Anderson 46016
Dillard Marcum, Adm.

MARION COUNTY

Altenheim of the United Church Homes, Inc.
(Formerly The Altenheim of Indpls.)
2007 N. Capitol Ave., Indpls. 46202
Helen B. Nugent, Adm.

MORGAN COUNTY

Morgantown Nursing Center
(Formerly Henderson Nursing Home)
140 W. Washington St., Morgantown 46160
Lillian Frye & Michael L. Hovious, Adms.

POSEY COUNTY

Medco Center of Mt. Vernon, Indiana
(Formerly Valley Rest Home)
1415 Country Club Rd., Mt. Vernon 47620
Donald D. Bruce, Adm.

RIPLEY COUNTY

Gray's Nursing Home
(Formerly Schwing Nursing Home)
R. R. #1, Sunman 47041
Charles L & Irene Gray, Adms.

WELLS COUNTY

National Nursing Home of Bluffton
(Formerly Davis National Nursing Home)
1001 South Clark Ave., Bluffton 46714
I. Helen Jackson, Adm.

DELETIONS

County

BENTON: Mary's Nursing Home, Earl Park

DELAWARE: Eads' Nursing Home, Muncie

Morgan Nickols Convalescent Home, Muncie

ELKHART: Treva's Nursing Home, Elkhart

FULTON: Rochester Nursing Home, Rochester

HANCOCK: Wood Nursing Home, Greenfield

LAGRANGE: LaGrange Community Nursing Home, LaGrange

LAKE: "Woodmar" Nursing Home, Hammond

LAWRENCE: Blackburn Rest Home, Bedford

MARION: Alpha Home for Aged, Indianapolis

MARSHALL: T L C Nursing Home, Argos

MIAMI: The Miami Home, Peru

ST. JOSEPH: River Park Nursing Home #1, South Bend

WAYNE: Twin Pines Nursing Home, Economy ◄

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Letter to the editor

To the editor:

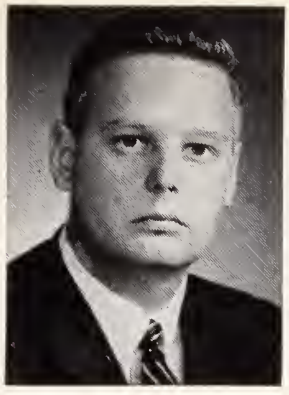
In the July 1971 *Readers' Digest* on page 49 the article STILL DYING FOR A SMOKE should be read by all smokers of cigarettes or cigars. In my office I have a sign acquired from the AMA which says "I advise my patients not to smoke cigarettes." Above all, a pregnant woman should not smoke and inhale cigarette smoke. Two examples of families with stunted children:

1. A woman now 34 married at 16 has seven children ages 7-17. At 23 years of age she began smoking cigarettes. Her three older children are normal. Her four younger ones are stunted mentally and physically; e.g., the three younger boys during the 1970-71 school year were all in the second grade.

2. A woman 30 who smokes a pack or pack and a half of cigarettes a day has five children, all under par physically. "They don't grow well" she says; e.g., the youngest, a girl, age 7 months, weighs 12 pounds.

Respectfully yours,
JOHN R. FRANK, M.D.
23 Lincolnway
Valparaiso 46383

TAX TIPS



by LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

MANY of you who have formed professional or other corporations with few shareholders have been concerned with what you may do with the funds that you already deposited into a qualified retirement plan (H.R. 10). You probably decided that you should not withdraw the funds and that you could stop making contributions to your plan. However, you discovered that if you did stop making contributions, then unfortunately, any life insurance policies (that you were purchasing under the plan) lapsed. Now, there is an I.R.S. Letter Ruling (CCH §55, 259) that may provide a very important aid to you. That is, the I.R.S. will allow you, under certain conditions, to transfer your H.R. 10 funds into the trust that governs your corporate plans, and such transfers will not cause recognition of income or the imposition of penalties. If you have this problem, then you should consult your lawyer about the ruling at once.

The recent case of *Estate of Bernard L. Porter v. Commissioner*, (1st Cir. 5/10/71) indirectly approved an important estate planning device for keeping death benefits (paid to an employee's spouse) out of the employee's gross estate for federal estate tax purposes. In this case, the court indicated that if a decedent had a contract with his employer under which the employee could not obtain any payments during his life, then the benefits under the contract may be excluded from the employee's gross estate for estate tax purposes. One key fact was that the decedent could not obtain any of the "death benefit payments" during his life. That is, the decedent could not obtain payments under the contract during his life either as an annuity or as a lump-sum payment. This scheme, if it continues to be approved by courts, is a bonanza for semi-retired owners of close corporations, because by careful planning such persons may avoid the effects of I.R.C. §2033, §2035, §2036, §2038 and §2039. You might ask your lawyer whether he thinks that such a plan is advisable in your particular situation.

The I.R.S. and courts are not in agreement about the amount of life insurance proceeds and premiums that are includable in a decedent-insured's gross estate for federal income tax purposes where a decedent gave away a life insurance policy during his life but continued to pay premiums on the policy. Therefore, it seems to me that individuals who are insured and who want to give away their life insurance policies in order to avoid federal estate taxes should have their lawyer consider having the premiums paid by someone other than the donor.

I doubt if many of you have ever read a question which has appeared on the Indiana bar examination which law school graduates take in order to be admitted to practice law in Indiana. Therefore, you might be interested in reading the two tax questions that appeared in the July 1971 examination.

1. Mr. B is a middle-aged successful businessman whose wife has been deceased for a number of years. He and Trixie, his girl friend of long standing, have decided to be married at 1:00 p.m. on New Year's Day. As a token of his esteem Mr. B plans to give Trixie $100,000. He comes to your office on December 15 and tells you that he is going to give Trixie part of the money on Christmas Day and the balance the morning of the wedding day. He has made no prior taxable gifts. He inquires concerning the federal gift tax consequences and asks for suggestions. He is adamant about the times of the payments but is open to suggestions as to the breakdown of the amount. State in what amounts you would recommend he make the two payments and calculate the tax. If you could get him to change the time of the second payment, what would you suggest and show the amount of difference, if any, this would make in the tax. Finally, he also asks you what the tax would be if he made the gift in two equal payments, the first on Christmas Day and the second on the morning of the wedding. What would it be?

2. P is a professional man with a very substantial income but has accumulated no money or property. He is married and is deeply obligated morally to his wife who worked to finance his education, and by whom he has two daughters, age four and six. Mrs. P is capable of earning about $6,000 a year as an organist in night spots, work which she can do without interfering with her care of the children. Mr. P has fallen for a young blonde and wants a divorce, although he has little or nothing by way of grounds. Mrs. P is willing to let him go but wants provision made for herself and the children. You represent Mrs. P. His lawyers offer a property settlement of $240,000 payable in equal annual installments over 12 years, which is to be in full for all obligations to

the wife as alimony and otherwise and as support for the children. What changes in the property settlement and what other terms would you insist on to protect the interests of your client and her children from the standpoint of federal taxation and why? ◄

New Indiana Law Concerning Public Health

HOUSE ENROLLED ACT No. 1679

AN ACT to amend IC 1971, 16-1-17, concerning public health.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 1971, 16-1-17-4 (formerly Acts 1949, c. 157, s. 1225) is amended to read as follows: Sec. 4. If the death or stillbirth occurred without medical attendance, or if the physician last in attendance is physically or mentally unable to sign the certificate of death or stillbirth, the local health officer shall inquire into the cause of death from such person or persons having knowledge of the facts regarding the cause of death. The local health officer is empowered to issue a subpoena to obtain such information and to employ a qualified pathologist to perform an autopsy when in the judgment of the local health officer such procedures are required to complete the inquiry. The local health officer shall then certify the cause of death on the basis of such information.

SEC. 2. IC 1971, 16-1-17 (formerly Acts 1949, c. 157) is amended by adding a new section to read as follows: Sec. 4.5. This chapter shall not be construed as an investiture of the local health officer with authority to convoke an inquest within the meaning of the statutes governing inquests.

SEC. 3. IC 1971, 16-1-17 (formerly Acts of 1949, c. 157) is amended by adding a new section to read as follows: Sec. 4.6. This chapter shall not be construed to repeal or amend other laws or parts of laws concerning autopsies but shall be considered to supplement previous laws, nor shall this chapter be construed as to require consent for a local health officer to order or perform an autopsy in the discharge of his duties.

SEC. 4. IC 1971, 16-1-17 (formerly Acts 1949, c. 157) is amended by adding a new section to read as follows: Sec. 4.7. Payment for autopsies as may be required by the local health officer shall be made from funds appropriated to the local health department.

SEC. 5. IC 1971, 16-1-17 (formerly Acts 1949, c. 157) is amended by adding a new section to read as follows: Sec. 4.8. The allocation of powers and duties as provided in this chapter shall not affect any action or proceeding of whatever nature thereto appertaining and pending at the time of the passage of this chapter. No contract heretofore entered into in accordance with law shall be affected, and any responsibility previously incurred in good faith in the determination of the cause of death shall be performed within the meaning of this chapter.

SEC. 6. (Severable) If any provision of this act or its application is held to be invalid, such invalidity shall not affect other provisions of the act which can be given effect without the invalid provision or application.

SEC. 7. (Emergency) Whereas an emergency exists for the more immediate taking effect of this act, the same shall be in full force from and after its passage.

Letters . . .

Editor's Note: The following letter was written in response to Dr. Alcorn's request for advice on the question of recruiting physicians from overseas for practice in doctorless communities. Dr. Hilton Read is famous enough to have been the subject of the biographical specialty "My Most Unforgettable Character" in READER'S DIGEST. He is a good enough doctor in a small community to be called Doc Read, and he is considered by Dr. Alcorn to be one of the best authorities on the subject of importing foreign physicians because his Ventnor Foundation has made friends with and assisted more than 750 physicians from five foreign countries.

August 20, 1971

Dr. Merritt O. Alcorn
President of Indiana State
Board of Medical Registration
and Examination

Dear Dr. Alcorn:

A physician from a foreign country can *PRACTICE* successfully in the United State without a period of time to become acquainted with drugs, etc. *But*, that would be a rarity.

We urge all young physicians to take an internship in the United States under our program even before taking on a residency. They do much better that way for many obvious reasons of which you are aware. There is a tendency among these physicians to feel that they are ready for residency and they get ready acceptance from even hospitals in high places who are so short handed. But it is a near disaster in many cases on both sides of the arrangements.

I am sure you are aware of the rules of ECFMG, and I suppose state boards could waive ECFMG certification and set up their own rules that they wish. I think it would be highly undesirable. You will recall that prior to the war (World War II) we did give reciprocity to physicians from other countries where they graduated from an AMA approved school. But the AMA was unable to continue this surveillance and approval and that was how I got into the picture in 1951 when I went to Europe for the State Department to see what the status was of the European medical schools. ECFMG was the answer a few years after that. I don't think that is a particularly *good* answer and I opposed it vigorously but now we have learned to live with it.

Germany at the moment is so prosperous and the doctors have it better than we do (I recognize the generalization is dangerous but I am in fairly close contact with the situation) and chances are that among the candidates that Mr. Willkie is interested in would be a fair number malcontents. We have had some of our exchangees who have elected to stay in this country (16% of our total) return to their homeland after they practice as long as eight years in this country.

I would think (and would approve of the idea) that you might consider waiving ECFMG (which gives an almost impossible examination for anybody out of medical school for more than a year or so) and let them take your state board examination *after* a year of residency or internship in Indiana, no matter what their age was. ECFMG, as you know, is proud of their flunk rate and I think they are a disgrace.

Other countries resent the brain drain but at the moment many of the countries have an excess of doctors and Germany is getting into that class now with a larger number of graduates. For awhile they had very few candidates for medicine and there were years not too far back when Heidelberg only had four entering students because of the monetary attraction of nuclear physics, engineering, etc. But now the trend is reversed. Most of these doctors are long on theory and short on practice. They have a great deal of "book larnin" and after a year's internship generally make exceptionally good doctors. They are very industrious—not clock watchers—and in many cases make satisfactory adjustments as to giving tender loving care. But they do need the American touch by way of internship or residency.

I am sure other countries would be offended (and it would have a bad impact on international understanding and brotherhood) if you waive the requirement for Germany or Austria and I am pretty sure that other minority groups could put up a pretty strong case for discrimination in that case and I don't think any court would sustain such a ruling. As you know, India became disaffected some years ago and refused to allow ECFMG to give its examination in India anymore. But we still get plenty of India candidates on our program because they are able to circumvent the ruling by taking the examination in Columbia or Iran or some other country. How does Mr. Willkie propose to keep them working in the rural areas where you probably need them the most? That is the toughest nut of all, as I see it. So far as I know, nobody has ever devised a way to give a limited license to practice in a given community.

I am aware of several other experiments that individuals have inaugurated to try to recruit foreign doctors for practice in this country as well as individual hospitals trying to recruit interns. I am not aware of any successful plan to recruit physicians to practice in a locality that is *foreign* physicians. They have generally wound up with one big headache.

I would appreciate a progress report from you as to how this program goes on.

Cordially yours,
Hilton S. Read, M.D.
THE VENTNOR FOUNDATION
5407 Atlantic Ave.,
Ventnor City, N.Y. 08406

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NOTE: Not recommended during the acute recovery phase following myocardial infarction. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. Concurrent electroshock therapy may increase the hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue the drug several days before elective surgery if possible. Should not be given to patients who have received an MAOI within two weeks.

Contraindications: Known hypersensitivity. Should not be given concomitantly with or within at least 14 days following the discontinuance of a monoamine oxidase inhibitor. Then initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction or for patients under 12 years of age.

Warnings: May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with narrow-angle glaucoma or increased intraocular pressure. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established; in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child.

Precautions: When used to treat the depressive component of schizophrenia, psychotic symptoms may be aggravated; in manic-depressive psychosis, depressed patients may experience a shift toward the manic phase, and paranoid delusions, with or without associated hostility, may be exaggerated; in any of these circumstances, it may be advisable to reduce the dose of amitriptyline HCl, or to use a major tranquilizing drug, such as perphenazine, concurrently.

When given with anticholinergic agents or sympathomimetic drugs, close supervision and careful adjustment of dosages are required. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent electroshock therapy may increase the hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue the drug several days before elective surgery if possible.

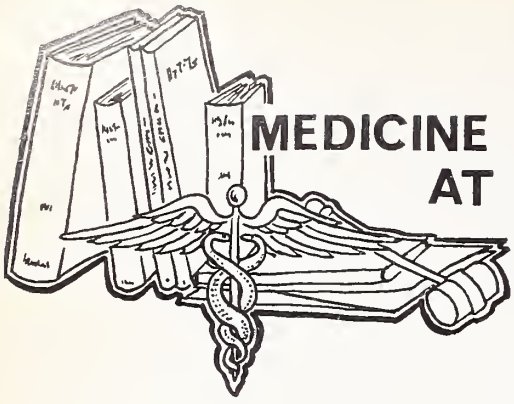
Adverse Reactions: *Note:* Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms. *Anticholinergic:* Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling. *Endocrine:* Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido. *Other:* Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice. *Withdrawal Symptoms:* Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction.

How Supplied: Tablets containing 10 mg and 25 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100, 1000, and 5000; tablets containing 50 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100 and 1000; for intramuscular use, in 10-cc vials containing per cc: 10 mg amitriptyline HCl, 44 mg dextrose, and 1.5 mg methylparaben and 0.2 mg propylparaben as preservatives.

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MEDICINE AT LAW

Juror Consults Own Physician in Medical Malpractice Lawsuit— In a medical malpractice lawsuit, it was error for a juror to consult his own physician concerning the medical aspects of the case, a California appellate court ruled.

A jury returned a verdict in favor of a hospital in a malpractice action involving viral encephalitis. The patient's family then filed a motion for a new trial. The motion was supported by the affidavits of several jurors. The affidavits stated that one juror had told them that he had consulted his own physician about viral encephalitis. The juror said that his own physician told him that viral encephalitis was an incurable disease and that the patient was doomed from the beginning.

The trial court granted the motion for a new trial, and the hospital appealed.

Vacating the order for a new trial, the appellate court ordered that the trial court conduct a further hearing into the alleged misconduct of the juror. Bias or prejudice of a juror is ground for a new trial, the court noted. However, since the alleged improper conduct was shown only by hearsay evidence, the court ordered that a more complete hearing be conducted into the matter.—*Weathers v. Kaiser Foundation Hospitals,* 92 Cal. Rptr. 557 (Cal. Ct. of App., Jan. 27, 1971).

Death Certificate not Evidence as to Cause of Death—A death certificate containing no opinion as to the cause of death was properly excluded as proof of the cause of death. It was also excluded for use in cross-examination of expert medical witnesses, a federal appellate court ruled.

A patient suffered cardiac arrest during a bone graft operation and died soon after. The administratrix of his estate brought action for wrongful death, seeking to prove that the anesthesiologists on the hospital staff had selected the wrong anesthetic, which decreased the oxygen supply to the patient's brain and caused the heart attack. The trial court entered a verdict for the hospital and anesthesiologists.

On appeal the issue was whether the trial court committed prejudicial error in refusing to admit the death certificate as proof of the cause of death and in refusing to permit it to be used in cross-examination of expert medical witnesses.

The death certificate listed as cause of death "sliding bone graft, under nitrous oxide and thiopental anesthesia for non-union, following fracture of left tibia." The court said that since the certificate merely described the operation and the type of anesthesia used, and did not refer to a medical condition that could be construed as a cause of death or to an opinion of the Medical Examiner as to the cause of death, it was properly excluded. The judgment of the trial court was affirmed.—*McSparran v. City of Philadelphia,* 433 F. 2d 976 (C. A. 3, Nov. 2, 1970).

No Liability for Cervical Neurectomy—A patient in whom a shoulder deformity developed after neck surgery was denied recovery from two physicians and the hospital by an Illinios jury.

A 47-year-old lumber worker, who was a lifetime smoker, underwent a cervical neurectomy, an operation done with local anesthetic to release bronchial muscles in emphysema patients. When he drove back to his home a week later, against the doctor's orders, a "winged scapula" shoulder deformity developed.

The patient brought action for malpractice, contending that his shoulder deformity was caused by a severed nerve. He also charged the hospital with inadequate staffing of its operating room.

The physician said that the shoulder deformity was usually caused by infection and that if it had been caused by a nerve it would have happened immediately. He stated that he had performed 160 such operations successfully.

The attorney for the patient asked the jury to award the patient $275,000. The hospital made an offer of $20,000. The jury denied damages to the patient.—*Partee v. Mayne* (Ill. Cir. Ct., Cook Co., Docket No. 70C-789, March 20, 1971).

Alcoholic Patient Wins Suit for Burns after Setting Fire to Hospital Bed—An alcoholic patient who suffered burns when she set fire to her hospital bed was awarded $60,000 by an Illinois jury. The award was against the hospital. The physician was held not liable.

A 38-year-old woman who was hospitalized for a skin disorder had delirium tremens and hallucinations. Cigarettes and matches were taken from her at midnight. At 2:00 a.m., she went to another patient's room

to look for matches. She was then restrained in bed. At 4:40, while trying to free herself from the restraints by using matches, she set fire to the bed. She suffered second and third degree burns on both legs and on her left hand, wrist and forearm.

The patient brought action for damages against the hospital and against the physician who ordered the restraints, charging that the search for matches had been inadequate and that the door to her room should not have been closed. The hospital contended that it did not know the woman was an alcoholic.

The woman had incurred debts of $4,000 in doctor bills and $6,000 for hospitalization. Her attorney asked for an award of $50,000. The jury brought in a directed verdict for the physician and awarded the patient $60,000 against the hospital.—*Franck v. Holy Family Hospital* (Ill. Cir. Ct., Cook Co., Docket No. 66L-1069, March 15, 1971). ◄

New Members, Additions to Roster of ISMA

The following physicians are new members of the Indiana State Medical Association:

BENTON

Manley Scheurich, M.D.
Oxford, Indiana 47971

GRANT

Santi Vibul, M.D.
Davis Clinic
Marion, Indiana 46952

LAKE

Stanley H. Enker, M.D.
7905 Calumet
Munster, Indiana 46321

Feliciano F. Jimeivez, M.D.
7950 South Kennedy Ave.
Highland, Indiana 46322

Frederick E. Wideman, M.D.
6111 Harrison
Merrillville, Indiana 46410

RIPLEY

Armand E. Jaojoco, M.D.
12 E. Boehringer St.
Batesville, Indiana 47003

ST. JOSEPH

Joventio Naval, M.D.
408 North Main Street
North Liberty, Indiana 46554

Luis Salazar, M.D.
St. Joseph Hospital
811 East Madison Street
South Bend, Indiana 46615

VIGO

Robert C. Oehler, M.D.
400 8th Avenue
Terre Haute, Indiana 47807

In addition, names of the following full-dues-paying members were omitted from the June 1971 Roster. The Journal regrets any embarrassment or inconvenience caused by the error.

Aronoff, Michael S., M.D. (Marion)
600 N. Jordan, Bloomington 47401

Dy, James T., M.D. (Porter)
2646 P. Lois St., Portage 46368

Dy, Juley T., M.D. (Porter)
2646 P. Lois St., Portage 46368

Sellers, Francis M. (St. Joseph)
Box P, University of Notre Dame, Notre Dame 46556.

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(fluoxymesterone Upjohn)

oral replacement with parenteral-like potency



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Indications *Male:* Replacement therapy in testicular hormone deficiency states. Prevents atrophy of the accessory male sex organs following castration for as long as therapy is continued. Impotence and male climacteric symptoms when due to androgen deficiency. Primary eunuchoidism and eunuchism. Delayed puberty when established as not a simple familial trait. Indicated for those symptoms of panhypopituitarism related to hypogonadism, however, appropriate adrenal cortical and thyroid hormone replacement therapy remain of primary importance. *Female:* Palliation of androgen-responsive, advanced, inoperable breast cancer in women between 1 and 5 years postmenopausal or women in whom castration has shown the tumor to be hormone dependent. Prevention of postpartum breast manifestations of pain and engorgement; there is no satisfactory evidence that this drug prevents or suppresses lactation per se. In osteoporosis androgens may be of adjunctive value to adequate considerations of diet, calcium balance, physiotherapy and general health promoting measures. *Males and Females:* In the treatment of protein depletion states which occur in geriatric patients, in debilitation states, in chronic corticoid therapy, resistant fractures; cryptorchidism; creating a positive nitrogen balance, tissue repair and other anabolic effects. Androgenic steroids may produce a response in aplastic anemias, myelofibrosis, myelosclerosis, agnogenic myeloid metaplasia and hypoplastic anemias due to malignancy or myelotoxic drugs. Androgens are not of value in other anemias.
Contraindications Pregnancy (may virilize female fetus), mammary carcinoma in the male, prostatic carcinoma, severe liver disease, severe cardiorenal disease and severe persistent hypercalcemia.
Precautions Employ with caution in young boys to avoid precocious sexual development and premature epiphyseal closure. Androgens tend to promote retention of sodium and water, therefore, watch for edema—particularly in the elderly. Incidence and severity of edema have been minimal and have been associated only with high doses used for palliation of breast cancer. Hypercalcemia may occur, particularly in patients with metastatic breast carcinoma; if this occurs the drug should be discontinued. Changes in liver function tests, such as increased BSP retention and SGOT levels, can occur during therapy. Jaundice has been rarely reported. If liver function tests are altered, discontinue medication or reduce dose. Priapism is indicative of excessive dosage and is indication for temporary withdrawal of drug. When treating protein depletion states or osteoporosis, an adequate diet should be provided and prolonged immobilization avoided whenever possible. When treating aplastic or hypoplastic anemias, androgen therapy should not replace other measure such as transfusion, correction of iron deficiency, antibacterial therapy, and the use of corticosteroids.
Adverse reactions Nausea, dyspepsia, menstrual irregularities, hepatic dysfunction, priapism, edema, precocious sexual development, and premature epiphyseal closure in young patients have been reported. *Male*—Prolonged administration or excessive dose may cause inhibition of testicular function with oligospermia and decreased ejaculation volume. *Female*—Large doses or prolonged administration may produce masculinization with signs such as hirsutism, deepening of the voice, enlargement of the clitoris, acne, and sometimes, increased libido.
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ABSTRACTS, BOOK REVIEWS

SYNOPSIS OF CLINICAL CANCER

Condict Moore, M.D., C. V. Mosby Company, St. Louis, 2nd edition, 1970; 267 pages; 37 illustrations; $11.75.

This book does not give detailed information on all cancers, and yet it is complete enough to meet the need of medical students, house staffs and practitioners. As the author has expected, it indeed serves as an introduction to cancer, a first reference or a handy review on cancer.

The book has 34 chapters and presents pertinent coverage on the cancers seen in daily practice. The cancers are described according to the organ or organs involved. There are chapters on Carcinogenesis, Leukemia, Chemotherapy and Reporting in Cancer. The book is easy to read and the information is up to date. The printing and illustrations are of superior quality. I would like to recommend this book as a first reference on cancer.

WEI-PING LOH, M.D.
Gary

STUDIES IN CLINICAL ENZYMOLOGY

D. P. Mullan, C. V. Mosby Company, St. Louis, 1969; 238 pages; $12.00.

This book was written and printed in Great Britain. It is a monograph. Certain sections of the book are useful to physicians and yet other areas are of general biological interest only.

It has 11 chapters, including Enzyme Studies in African Heart Disease, which appears to be of special interest. Some of the terms used are not popular in this country. The references listed are generally a few years behind. The printing and illustrations, including photographs, are of only fair quality.

WEI-PING LOH, M.D.
Gary

MICROMETHODS FOR THE CLINICAL AND BIOCHEMICAL LABORATORY

H. Mattenheimer, Ann Arbor Science Publishers, 1970; $18.75.

Much of the material in this book appears to be translation from original writing in German. The equipment discussed is often foreign made and is not popular or readily available in this country. The quality control for the important procedures is not discussed. In additon, there is lack of clarification for normal values in some procedures in term of age range.

On the other hand, the book is easy to read and the format of presentation is superb. The printing is of average quality.

JOAN SOHANEY, MT (ASCP), M.S.
WEI-PING LOH, M.D.
Gary

BIOLOGICAL RHYTHMS IN PSYCHIATRY AND MEDICINE

Public Health Service Publication #2088; National Institutes of Mental Health; prepared by Gay G. Luce, 1970; 183 pages with several illustrations; paper back, $1.75.

Even in these days of spiraling inflation, one does stumble

across a genuine bargain: as witness this little masterpiece. While visiting the scientific exhibits at the AMA meetings held in Atlantic City, I passed the Mental Health booth. The presentations were most attractive; the bulletins were stacked and being given away free for those signing up. I scrutinized the items—I took along this publication. Seldom have I felt more rewarded.

In extremely clear, elementary language, we are regaled with the whole bit on Circadian rhythms, their development, the physiological clock hands for emotion and memory, photoperiodism, work-rest schedules—just about the entire very complicated subject in about the simplest language possible!

Biological rhythms are related in terms of sleep research. The rhythm that has a higher frequency than a day is "ultradian"; this makes them shorter than circadian. When the cycles are longer than circadian—cycles of weeks and months—we are introduced to the word "infradian." Then the entire relationship is elucidated in biological terms of hormone secretions, REM sleep movements, etc.

Seldom have I enjoyed so unexpectedly, so totally, an accidental find. The paper and binding and printing are high quality. Try this bulletin. I'm certain you'll share my pleasure.

ARNOLD LIEBERMAN, M.D.
New York City

MOLECULAR PROPERTIES OF DRUG RECEPTORS

Ciba Foundation Symposium—edited by Ruth Porter and Maeve O'Connor—J.&A. Churchill, London, England, 1970, 298 pages with numerous tables and illustrations; $12.50.

The usual score or so of eminent specialists on this particular frontier of research held a long and earnest colloquium as to just exactly *HOW* neuro-transmission takes place on the molecular tridimensional level.

The topic of alpha and beta receptors and antagonists is being pursued further into the stereoisomeric molecular shapes of agonists and *anta*gonists; what and which ligand does just how and where; what are the active sites of the lysozomes; just how *do* the receptors in the post synaptic membrane of the motor end plate function: just what are the conformational transitions in the course of membrane excitation: the still dimly discerned, mist enshrouded, of memory imprinting molecule intertwining—confusing termins but steadily becoming more comprehensible.

Still veiled in the mists of the future, we are being hand-led into and up to heights which begin to give us glimpses of the future. It is stimulating even if still incomprehensible to such M.D.s as you and I.

As usual, the printing, binding and paper cannot be faulted. I look wistfully to the day when such a symposium can be written down to a more comprehensible level.

ARNOLD LIEBERMAN, M.D.
New York

Abstracts from Various Literature, Prepared by AMA

SEATBELT INJURIES OF SPINE AND ABDOMEN

J. R. Dehner (Reid Memorial Hosp. Richmond, Ind. 47374).
Amer. J. Roentgen. 111:833-843 (April) 1971.

At least 40 cases of serious injury to the spine have been reported with the lap seatbelt. The trauma to spine is produced by severe flexion of torso over belt, causing a tearing of posterior elements, with less involvement of vertebral bodies. One of the interesting intermediate forms of vertebral injury is the Chance fracture, a horizontal splitting and separation of posterior vertebral arch, involving the pedicles, lamina, transverse processes, and spinous process, with variations. Following seatbelt trauma to the abdomen, the most common injury is perforation of the small bowel with associated trauma of its mesentery. Injury to almost every hollow and solid viscus in the abdomen has been reported, and multiple injuries are common. Combined injuries of the spine and intra-abdominal contents occur. The diagonal belt and the combination lap-and-diagonal belt have produced injury to the sternum, ribs, and upper abdomen. The diagonal belt prevents the lumbar flexion fracture seen with the lap belt but may produce a flexion-type injury in the neck. The shoulder harness used with the lap belt should be evaluated to replace the lap-and-diagonal belt.

RETROPERITONEAL INJURY TO DUODENUM BY BLUNT ABDOMINAL TRAUMA: REPORT OF EIGHT CASES

T. S. Wilson and L. B. Costopoulos (Dept. of Surgery, Univ. of Alberta, Edmonton)
Canad. J. Surg. 14:114-121 (March) 1971.

Eight patients with duodenal injury are reported over a 15-year period. Two were patients with duodenal hematoma; six had perforation. Minor injuries are probably common, and should be considered in anyone who complains of epigastric or central deep seated abdominal pain. Hematoma often develops slowly, signs may be minimal, but persistent vomiting alerts the physician that obstruction is present. Diagnosis is confirmed by upper gastrointestinal x-ray series with barium. If the obstruction is not relieved by nasogastric suction and intravenous therapy, it may be bypassed by gastrojejunostomy. In perforation, a latent period with few signs and symptoms is often present. Plain abdominal films may show retro-peritoneal air, particularly around the right kidney. An emergency upper gastrointestinal series with gastrografin localizes the site of rupture. Surgical closure is advised.

CARCINOGENIC PROPERTIES OF WEAR PARTICLES FROM PROSTHESES MADE IN COBALT-CHROMIUM ALLOY

J. C. Heath (Strangeways Research Lab, Cambridge, England), M. A. R. Freeman and S. A. V. Swanson
Lancet 1:564-566 (March 20) 1971.

Particles produced by the working, in a bath of Ringer's solution, of an artificial total joint made from cobalt-chromium alloy have been shown to be carcinogenic for rat muscle.

NARCOTIC ADDICTION IN PREGNANCY

M. L. Stone et al. (1249 Fifth Ave., New York 10029)
Amer. J. Obstet. Gynec. 109:716-723 (March 1) 1971.

This study of over 300 female addicts demonstrated the problems they present. Over 90% of these women had no or inadequate prenatal care. The incidence of maternal complications has been markedly higher than in a general clinic population. Obstetric complications include prematurity, toxemia, breech births, and precipitate labor. Prostitution serves as the source of income to support the drug habit, and the incidence of venereal disease and hepatitis is increased. Over 70% of the neonates show congenital neo-

natal addiction with clinically recognizable withdrawal symptoms. These symptoms suggest hyperactivity of the autonomic nervous system as evidenced by diaphoresis, diarrhea, and rhinorrhea. Hypertonicity and a characteristic high-pitched, shrill cry are frequently observed. In addition to being premature by dates, 50% of these infants show evidence of retarded intrauterine growth.

EVALUATION OF GENTAMICIN WITH CARBENICILLIN IN INFECTIONS DUE TO GRAM-NEGATIVE BACILLI

J. Klastersky, R. Chappel, and L. Debusscher (Institut Jules Bordet, Brussels)

Curr. Ther. Res. 13:174-181 (March) 1971.

Gentamicin and carbenicillin were used to treat 34 patients with disseminated malignant diseases presenting severe infections due to gram-negative bacilli resistant to commonly used antibiotics. In vitro synergism between the two antibiotics was observed in 50% of the strains studied, and additive effect was documented in another 40%. In only six patients did therapy with gentamicin and carbenicillin fail to eradicate the microorganism responsible for the infection, and these patients died. Clinical response to therapy was better in patients infected with organisms on which gentamicin and carbenicillin were synergistic in vitro. Slight impairment of the renal function was observed in four cases (11%), but reverted when therapy was discontinued. Combination of gentamicin with carbenicillin appears to be an effective therapeutic regimen in severe infections suspected of being caused by *Pseudomonas* or other resistant gram-negative organisms.

OCCUPATIONAL FACTORS IN EPIDEMIOLOGY OF LEUKEMIA IN HIROSHIMA AND NAGASAKI

T. Ishimaru et al. (US Marine Corps Air Station, FPO Seattle 98764)

Amer. J. Epidem. 93:157-165 (March) 1971.

This epidemiology study examined retrospectively occupational and other environmental factors in relation to the incidence of leukemia. A total of 492 cases of leukemia with onset in 1945 to 1967 in Hiroshima or Nagasaki and controls were selected from the Atomic Bomb Casualty Commission Leukemia Registry and interviewed during the period 1966 to 1969. In 303 pairs of adult leukemia cases and controls the risk was approximately 2½ times higher among those with history of probable occupational exposure to benzene or its derivatives and medical x-ray.

PERFORMANCE OF DRIVERS WITH IMPAIRED COLOR SENSE IN TRAFFIC

E. Zahnder (Gerichtl Med. Institut der Universitat, Zurich, Switzerland)

Schweiz Med. Wschr. 101:530-536 (April 17) 1971.

The behavior in traffic of 160 color-blind drivers was compared with that of a control group with normal vision on the basis of offense and accident statistics. The total mileage driven by each group was about 80 million kilometers and 40% drove taxicabs, motorcoaches, trucks. No statistically significant differences were found between the two groups, nor was there any difference found in traffic performance between subjects with slight and those with severe color blindness. If otherwise qualified, color-blind individuals can be safely allowed to drive any type of vehicle. ◄

Pre-Sate® (chlorphentermine hydrochloride)

Caution: Federal law prohibits dispensing without prescription.

Indications
Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (i.e. several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.

Contraindications
Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.

Warnings
When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.
Drug Dependence Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with the high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.
Usage In Pregnancy The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.
Usage In Children Not recommended for use in children under 12 years of age.

Precautions
In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorectic agent and a restrictive dietary regimen.

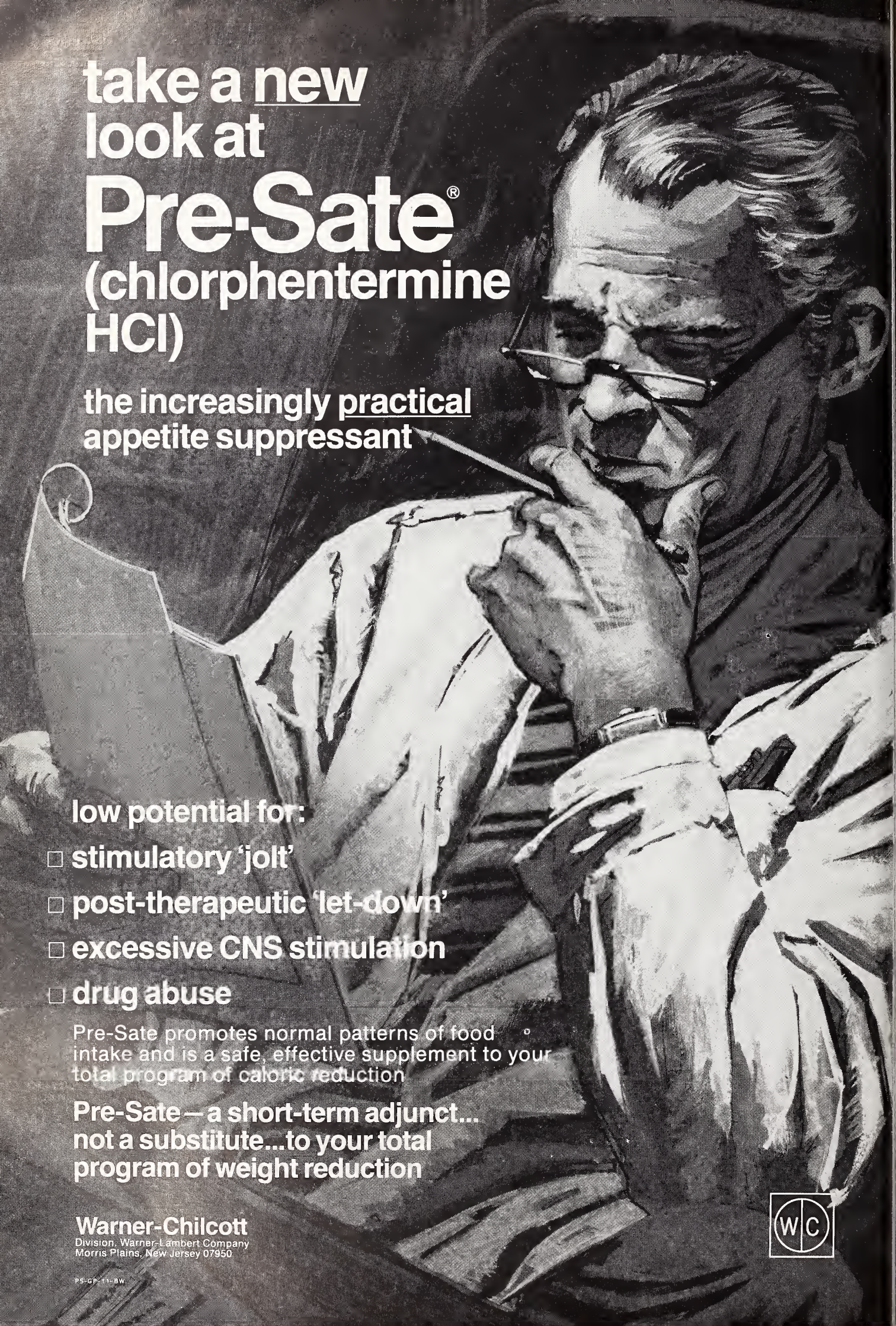
Adverse Reactions
Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.

Dosage and Administration
The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.

Overdosage
Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.
Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

How Supplied
Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.

Full information is available on request.


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Pre-Sate®
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the increasingly practical appetite suppressant
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Continuing Education For Physicians

POSTGRADUATE COURSES IN INDIANA

Achievement: Delayed or Never?

September 22, 1971—Indianapolis

Parents and primary physicians alike become concerned when a child's development varies from the average. The physician faces this dilemma: Should he raise the question of deviant development, at the risk of compounding parental anxiety and thereby possibly impairing their handling of the child? Or should he reassure the parents that everything will probably come out all right? And in cases where the physician decides on reassurance, at what point should he reconsider and raise questions about further evaluation? Then other questions face the family physician: How much evaluation can he do himself? Where can he seek assistance, and what facilities are available in the community? How can a physician manage problem parents, such as those exercising denial?

Morning session: discussion will center on the diagnosis of developmental problems — from prenatal period on through childhood. Discussants will also consider resultant problems of adjustment in a home having a child with deviant development: how to advise parents on helping the child to adjust in the home; how the parents themselves can make appropriate adjustments; how to help parents and child adjust to placement out of the home. Afternoon session: attention will turn to types of care outside the home: foster-home care, day care, residential care, and institutionalization. The course will close with discussion of new perspectives and the hope they offer for the future.

The course format includes panel discussion, video tapes and open forum discussion in which all participants are invited to share their own experiences.

Director: Dr. C. Raymond Kiefer, assistant professor of psychiatry.

Dermatology: Recognition and Management of Common Disorders

October 6, 1971 — New Albany

This one-day course in Dermatology emphasizes skin disorders commonly encountered by the family physician. Movie film strips and clinical photographs will illustrate clinical entities, diagnostic procedures, and medical/surgical management. Didactic material will be limited to commentary accompanying the visual aids; generous time has been set aside for audience participation. Discussants will include members of the Dermatology Department of Indiana University Medical Center as well as dermatologists in private practice.

Director: Dr. Daniel H. Cannon.

Urban and Suburban Skid Row

October 14, 1971 — Indianapolis

This six-hour course is designed to help the family physician deal more effectively with problems of alcoholism encountered in general medical practice. Speakers from various fields will stress the multidisciplinary approach to alcoholism: the social, physiological, medical, psychiatric and legal aspects.

Director: Dr. Hanus J. Grosz, professor of psychiatry, director of alcoholism research training.

Diabetes — An International Review — The 50th Anniversary of Insulin

October 21-23, 1971 — Indianapolis

This two-and-a-half-day course, given on the 50th Anniversary of Insulin, will cover recent advances in diabetes with special emphasis on Insulin. The course will start with presentations by world authorities and pioneers in Insulin research. These will be followed by discussions at the basic science and clinical levels of recent information on subjects of continuing importance to practicing internists who are interested in diabetes. Accordingly, Insulin and its mechanism of action, the natural history and complications of diabetes, diagnostic criteria in diabetes, and pros and cons of the UGDP study, will be discussed. The method of instruction will be primarily didactic with ample time allowed for discussion and questions. Luncheon workshops will review basic diabetic diets and consider fat-controlled diet modifications.

Director: Dr. C. Conrad Johnston, Jr., associate director of the General Clinical Research Center, professor of medicine;

Co-directors: Dr. John A. Galloway, assistant professor of medicine;

Dr. Steven C. Beering, associate dean, professor of medicine.

Clinical Neuro-Ophthalmology Workshop

November 3, 1971 — Indianapolis

The Clinical Neuro-Ophthalmology Workshop is a programmed course designed for ophthalmologists, neurologists, neurosurgeons and other interested physicians. Staff members will present case histories involving diseases of the oculomotor and visual systems. Then, prior to staff discussion of each patient, participants will be invited to answer a programmed series of printed questions—a self-assessment exercise to evaluate one's own clinical judgment.

The course will cover these subjects: MLF syndromes, cranial nerve palsies and other motor disorders, unilateral proptosis, chiasmal lesions, optic neuritis and related conditions.

Co-directors: Dr. Julius M. Goodman, neurosurgeon;

Dr. Mortimer Mann, ophthalmologist.

Carcinoma of the Head and Neck — A Multidisciplinary Approach

November 10, 1971 — Indianapolis

This course emphasizes a multidisciplinary approach to early diagnosis and management of more common head and neck cancers. Speakers will discuss recent developments among different therapy modalities: surgery, radiation and chemotherapy.

Nationally known speakers will join selected faculty from the Indiana University School of Medicine and the Indiana University School of Dentistry in discussing early diagnosis and management of head and neck cancer. The course format will allow ample time for participants to raise and discuss questions arising during the one-day course.

Director: Dr. Ned B. Hornback, chairman, and associate professor of radiation therapy.

Common Neurological Symptoms and Signs

November 17, 1971 — Indianapolis

Common neurological symptoms such as dizziness, fainting, headache, numbness and tingling frequently prove puzzling unless the physician can fit the symptom into a conceptual framework of differential diagnoses. Accordingly, this course is designed to sharpen the physician's diagnostic approach to common neurological symptoms and signs.

Also, the course will focus on certain mental symptoms which are frequently indications of organic CNS disease, and one session will center on learning and reading disorders in children.

The course format will include brief demonstrations and discussions of neurological signs. The one-day course will close with a panel discussion, and participants will have opportunity to raise and discuss questions.

Director: Dr. Joseph B. Green, professor of neurology.

Kidney and Genitourinary Disease — Core Material

December 8-9, 1971 — Indianapolis

The past decade has brought advances in the care of patients with kidney and other genitourinary problems. Core material developed for current medical students reflects these advances and serves as the basis for a refresher course for the practicing physician.

Most patients with kidney or genitourinary problems show certain signs: hematuria, proteinuria, pyuria, mass lesions, uremia, oliguria, hypertension, etc. These signs, as well as micturational symptoms, are commonly the starting point for the physician in his search for diagnosis and appropriate care.

This two-day review stresses the problem-solving approach, starting with the patient's presenting signs. By lecture and panel discussion, the staff will present the current core material of renal medicine.

Director: Dr. Richard J. Hamburger, assistant professor of medicine.

Law In Medicine

December 15, 1971 — Indianapolis

The postgraduate course Law In Medicine may well set precedent in Indiana. Hopefully, it is the beginning of a doctor-lawyer dialogue on topics common to the two professions.

This one-day course centers on two timely areas:

1) Medical malpractice screening panels versus medical arbitration experiments;
2) The 1971 revision of the Indiana Good Samaritan Law.

With the ever-increasing number of malpractice suits, doctors and lawyers alike are looking for means to resolve such conflicts outside the courtroom arena. Screening panels composed of physicians and lawyers have met with less than success. What are the alternatives? Should there be binding arbitration? Or no-fault insurance? Members from both sides of the aisle will discuss this crisis situation.

Director: Richard L. Schultheis, M.D., J.D., assistant professor of preventive medicine, assistant professor of law.

ELSEWHERE

The Cleveland Clinic Educational Foundation has released its postgraduate course schedule for 1971-72. It is as follows:

Psychiatric Aspects of Medical Practice for the General Physician
October 6 and 7, 1971

Renal Disease — Practical Applications
October 13 and 14, 1971

Clinical Aspects of Liver Disease
October 20 and 21, 1971

Problems in Internal Medicine
November 10 and 11, 1971

Neurosurgical Techniques
December 1 and 2, 1971

Current Concepts in Ophthalmology
December 8 and 9, 1971

Common Problems in General Surgery
January 12 and 13, 1972

General Practice
February 2 and 3, 1972

Thyroid Disease and Disorders of Calcium Metabolism
February 9 and 10, 1972

Learning Disabilities and the Physician
February 23, 1972

Medical Progress and Its Relationship to Dentistry
March 1 and 2, 1972

Advances in Urology
March 15 and 16, 1972

Practical Laboratory Chemistry — Manual and Automated
March 23 and 24, 1972

Diagnostic Immunology
April 5 and 6, 1972

Advances in Orthopaedic Surgery
April 19 and 20, 1972

New Concepts and Practices in Diseases of the Colon and Rectum
April 26 and 27, 1972

Arteriosclerosis and the Anesthesiologist
May 3 and 4, 1972

For further information and detailed programs, write: Director of Education, The Cleveland Clinic Educational Foundation, 2020 East 93rd St., Cleveland, Ohio 44106. ◄

FUTURE MEETINGS, SEMINARS, COURSES

Symposium on Polytomography Of Temporal Bone Announced

The fourth two-day Symposium on Polytomography of the Temporal Bone will be given under the auspices of The Wright Institute of Otology at Community Hospital, Indianapolis on October 9 and 10, 1971.

Subjects covered are: "Basic Anatomy of the Temporal Bone" and "Technique of Polytomography of the Temporal Bone" with demonstrations of normal tomograms. Pathological conditions revealed by polytomography, such as cholesteatoma, ossicular chain problems, otosclerosis, fractures, foreign bodies, tumors, and congenital anomalies are shown on original tomograms and the clinical applications discussed.

Number of registrants is limited to 18. Fee for the course is $150.00.

Inquiries should be directed to: The Wright Institute of Otology, Inc., Community Hospital of Indianapolis, Inc., 1500 North Ritter Avenue, Indianapolis, Ind. 46219.

Announce Hypnosis Society Meeting

The American Society of Clinical Hypnosis will hold its 14th Annual Scientific Meeting at the Pick Congress Hotel in Chicago October 10 to 16. The Workshop portion of the program is acceptable for 23 accredited hours by the AAGP. Non-member physicians may attend.

Clinical Reviews Set for November

The Mayo Clinic will hold its popular Clinical Reviews this year in November. One session will meet November 1, 2 and 3. A later session is scheduled for November 8, 9 and 10. Early registration is desired. A fee of $35 is charged. AAGP credit is given for 26 prescribed hours. Write Postgraduate Courses, Mayo Clinic, Rochester, Minn. 55901.

General Practice Review Scheduled

The University of Colorado School of Medicine is holding three sessions of its General Practice Review in 1972—January 24 to 29 and February 7 to 12 at Denver, and June 12-17 at Estes Park. For full particulars write The Office of Postgraduate Medical Education, 4200 E. Ninth Ave., Denver 80220. ◄

From *The Journal* 50 Years Ago

One of the most convincing evidences of medical progress is the fact that men in clinical medicine are beginning to pay attention to protein sensitization as a phase of disease production with which they have to deal. Ten or 15 years ago such subjects were not discussed except by scientists and investigators. . . .

That anaphylactic conditions are due to protein intoxication was discovered rather by accident, but investigators were not slow in pushing investigations on this relationship, and establishing a similar relationship in other groups of conditions. . . .

Furthermore, Vaughan found that, regardless of the type of protein, every protein contains in its chemical structure a toxic nucleus or split product which, when liberated by the chemical cleavage of the entire whole protein molecule, is one of the most potent poisons known. . . .

Further chemical work is being carried on concerning the character of the toxic split product to which I have referred. This has been identified by Dr. Abel of Johns Hopkins as histamin. He has found this as a structural part of proteins from various sources, and its introduction into animals produces death with symptoms identical with anaphylactic shock. He finds a similar substance in large amount in the pituitary gland, and suggests that the effect of pituitrin may be due to the presence in it of histamin. If that toxic portion of the protein molecule, which may be histamin, is responsible for the toxic symptoms present in bacterial infection, future research for the advancement of therapeutic medicine is going to be directed at that toxic substance. . . . . Virgil H. Moon, M.D., Indianapolis, "Protein Sensitization," *JISMA*, September 1921.



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Helps overpower pain

Each tablet contains: aspirin gr. 3½,
phenacetin gr. 2½, caffeine gr. ½.
No. 3 contains codeine phosphate* (32.4 mg.) gr. ½.
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CIII Empirin Compound with Codeine is now classified in Schedule III. Available on oral prescription and may be refilled 5 times within 6 months, unless restricted by State law.

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The Woman's Auxiliary

REPORTS TO ISMA



Our guest editor this month is Mrs. Dwight Schuster, State Auxiliary Medical Care Insurance Chairman. At both state and local levels Anne has proven her ability as a leader and organizer for the Auxiliary. I'm sure you will read her article with great interest.

Lelia M. Chernisky

One of the purposes of our Medical Auxiliary is to assist the medical profession in its public relations and education in the health care field. Our Blue Shield is a most cooperative and informative vehicle for doing this.

Our program for the year has three prerequisites for its success. WE MUST BE INFORMED . . . Blue Shield, as it has in the past, is again offering dinner workshops for the Medical Assistants in the doctors' offices. A representative from each county auxiliary is generously included in this invitation. You as doctors, can greatly assist in making this program a success by noting the calendar following this article and asking your office medical assistant to circle the proper date on her calendar for attendance. An invitation from Blue Shield will be forthcoming.

WE MUST BE CIVIC MINDED. . . It is no news to you doctors that an area of great concern today is the drug scene. Blue Shield has made available for use at no charge except return postage three excellent films concerning the drug problem: A MOVEABLE SCENE, narrated by Robert Mitchum and focusing on the so-called soft drugs such as Marijuana; The second flim, FLOWERS OF DARKNESS, narrated by Paul Newman, deals with "hard drugs" including many of the opiates; and BRIDGE FROM NOPLACE, narrated by Rod Steiger, concentrating on rehabilitation of the addict. As doctors and wives are active and respected in their communities, we can be excellent promoters of use of these films. Arrangements may be made with me or the Blue Shield office, for use of these films.

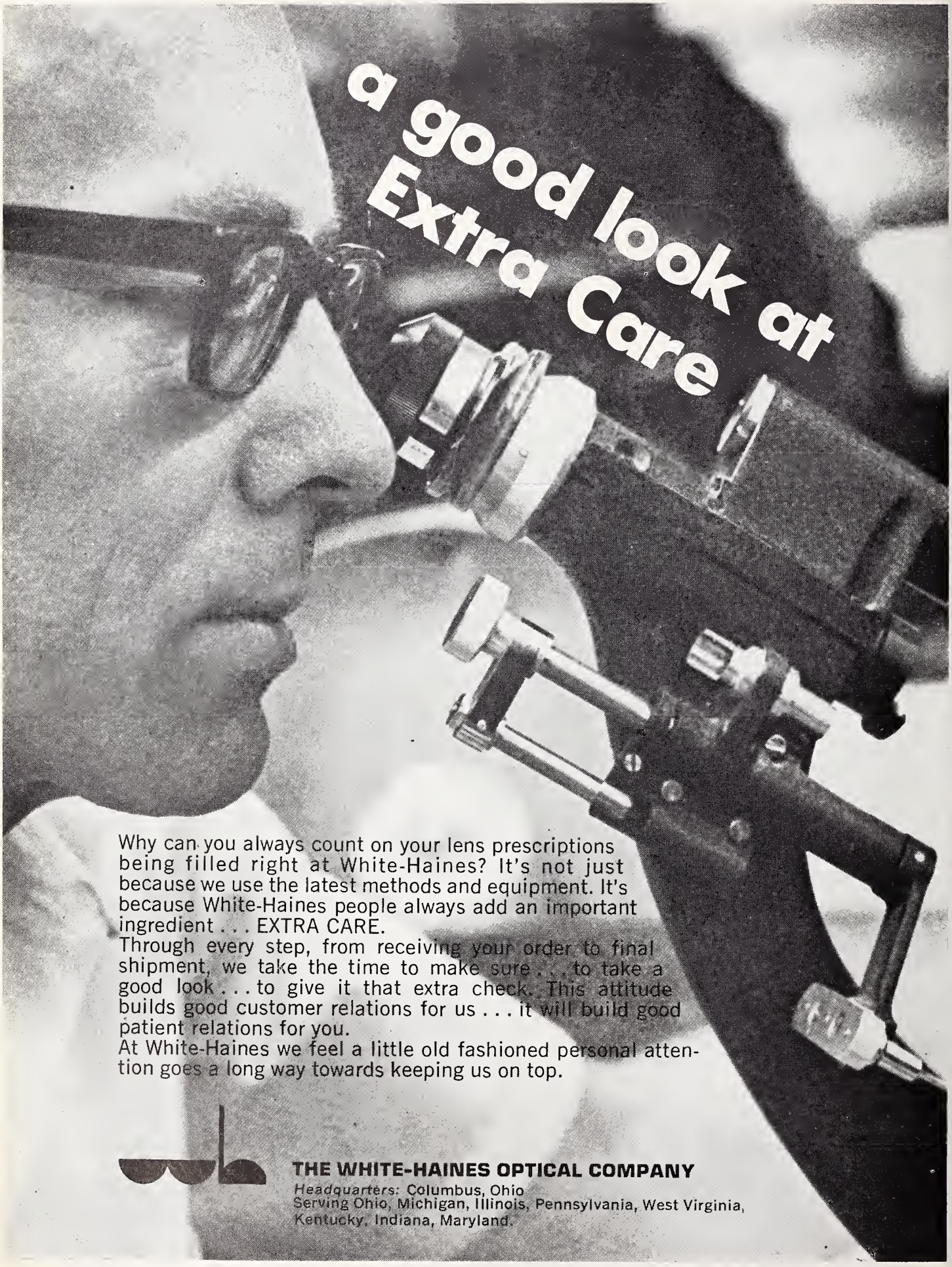
WE MUST BE VITALLY INTERESTED AND INVOLVED . . . in our legislative field. Many changes in our health care field are being proposed both on the local and national levels. The legislative activity will be of extreme importance to us.

Certainly the Auxiliary and the Association can help each other to be "an important cog in the wheel of success" in our Medical Care programs in the community by supporting the three areas mentioned in this article. May I again ask you please to check your calendar according to the schedule attached? Thank you for taking time from your busy schedule to read of our Auxiliary activities.

DATES AND LOCATIONS FOR DINNER SEMINARS:

Date	Place	City
Sept. 8	Elcona Country Club	Elkhart
Sept. 14	Pottawattomie Country Club	Michigan City
Sept. 15-16	Morris Park Country Club	South Bend
Sept. 21	Tippecanoe Country Club	Monticello
Sept. 22-23	Ramada Inn	East Gary
Sept. 27	Memorial Union, Purdue Univ.	Lafayette
Sept. 28	Adami's Restaurant	Brazil
Sept. 29	Elks Country Club	Vincennes
Oct. 5-6	Blue Cross-Blue Shield Cafeteria	Indianapolis
Oct. 19	Cutter's Chalet	Fort Wayne
Oct. 27	Ball State University	Muncie
Oct. 28	Forrest Hills Country Club	Richmond
Nov. 2	Madison Country Club	Madison
Nov. 3	Holiday Inn	Bloomington
Nov. 4	Imperial House	Columbus
Nov. 9	Executive Inn	Evansville
Nov. 16	Marriott Inn	Clarksville

Anne Schuster (Mrs. Dwight W.)
Medical Care Insurance Chairman



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Werner, Robert, 3825 N. Whittier Pl. Indianapolis, Ind. 46226

Pelletin, G. J., 32 Blandford St., Toronto, Ontario, Canada

Alt, K., 19 Orkney Cresent, Islington, Ontario, Canada

Robinson, Robert J., 9230 E. Giraid, Apt. 12, Denver, Colo. 80231

GENERAL SURGERY

Patel, Amboo K., P. O. Box 70, Inverness, Nova Scotia, Canada

Werschky, L. R., 48 A Hayward, China Lake, Calif. 93555 (Naval Weapons Center)

Comer, Thomas Patrick, 1007 Gables Blvd., Wheaton, Ill. 60187

Gazayerli, M. M., 14 Fath Drive #3, Cheektowaga, N.Y. 14225

Singal, Ram K., 18 Sussex Drive, Apt. 28, St. John, New Brunswick, Canada

Khalouf, Herbert C., 2036 Kem Rd., Marion, Ind. 46952

Sustaita, Hector, 30 Heather Place, Hillsborough, Calif. 94010

Baik, Kil Young, 884 Richmond Ave., Buffalo, N.Y. 14222

INTERNAL MEDICINE

Baird, Glenn D., 314 Vandenberg Dr., Biloxi, Miss. 39531

Patel, Kanu, Wayne County General Hosp., Eloise, Mich. 48132

Tan, Alfonso O., 229 Shrewsbury St., W. Boylston, Mass. 01583

Banerjee, Tarit K., Campus Tower, Apt. 1004, 87 Ave., Edmonton, Alberta Canada

Villavecer, Hermenegildo T., 4460 Granada Blvd., Apt. 17, Warrensville Heights, Ohio 44128

Klaus, Andrew P., 10388 Faulkner Ridge Circle, Columbia, Md. 21043

Roza, Otto, 12000 Fairhill Rd., Cleveland, Ohio 44120

Dutt, Katikuti E., 140 S. Johnson, Pontiac, Mich. 48053

NEUROSURGERY

Yballe, Danilo N., 4510 65th St., Sacramento, Calif. 95820

OPHTHALMOLOGY

Cowden, John W., 130th General Hosp., APO New York, N.Y. 09696

OBSTETRICS & GYNECOLOGY

Kulkarni, Durgadas, Greater Baltimore Medical Cntr., Baltimore, Md. 21204

PATHOLOGY

Gagliano, Elio F., 3333 W. 2nd St., 52-311, Los Angeles, Calif. 90004

PEDIATRICS

Malik, Rashidah B., 8-L, Aggie Village, C.S.U., Ft. Collins, Colo. 80521

Shaw, Lein-Chun, 547 Emerald St., Apt. A-10, Iowa City, Iowa 52240

PSYCHIATRY

Perrin, Joyce, 140 Linden Avenue, Long Beach, Calif. 90802

Fried, Frederick E., Menninger School of Psychiatry, 2601 E. 25th St., Topeka, Kan. 66605

Das, Arabinda, Fulton State Hosp. Dormitory, Fulton, Mo. 65251

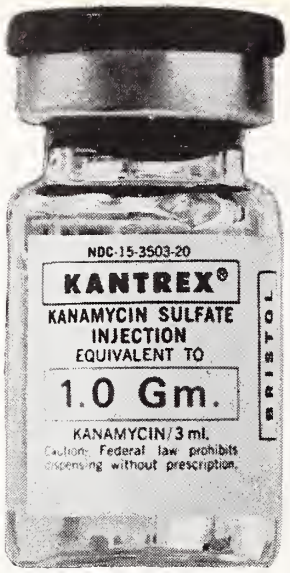
UROLOGY

Jam, Mohammad Nickbakht, 2804 Overland Ave., Baltimore, Md., 21214

Franco, Ned M., 136 Randolph St., Travis AFB, Calif. 94535 ◄



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And its economy.

Faced with a life-threatening infection, the physician cannot conscionably consider economy a primary factor in selection of an appropriate antibiotic. However, when susceptibility reports are in, the infecting pathogens are often found to be susceptible to several antibiotics. The physician may then consider dose requirements and cost in his prescribing decision.

Kantrex requires one simple standardized dose for almost any patient with any susceptible mixed Gram-negative/staph infection (Pseudomonas are resistant). The usual adult daily dose of Kantrex is only 1.0 Gm....and the usual total course of therapy, 7-10 Gm. Translated to dollars and cents, the daily cost of Kantrex therapy may be only 1/2 to 1/8 that of therapy with other parenteral antibiotics used for serious hospital infections.

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BRIEF SUMMARY OF PRESCRIBING INFORMATION
(8) 7/8/70
For complete information, consult Official Package Circular.

Warning: Irreversible deafness can occur. Tinnitus or vertigo may also occur and indicate vestibular damage and impending deafness. The risk is sharply increased with renal dysfunction. In such cases, decrease size and frequency of doses. Discontinue kanamycin and check hearing if azotemia increases. Watch carefully for ototoxicity in older patients and patients receiving more than 15 Gm. of kanamycin. To avoid neuromuscular paralysis with respiratory depression, postpone intraperitoneal instillation in post-operative patients until recovery from anesthesia and muscle relaxants is complete. Avoid concurrent use of other ototoxic drugs including ethacrynic acid. Safety in pregnancy is not established.

Indications: Serious infections due to susceptible strains of *E. coli*, Proteus sp., *Enterobacter aerogenes*, *K. pneumoniae*, *Serratia marcescens* and *Mima-Herellea*. Culture and sensitivity studies should be performed.
Contraindications: A history of hypersensitivity to the drug. Prior auditory damage by kanamycin or other agents may be a contraindication if effective alternative therapy is available.
Precautions: Obtain audiograms before and during therapy in patients with renal dysfunction when treatment lasts more than 5 days. Stop Kantrex if tinnitus or hearing loss occurs. Hydrate patients to prevent chemical irritation of the renal tubules. Assess renal function periodically, both before and during therapy. If signs of renal irritation occur (casts, cells, proteinuria) increase hydration and reduce the dosage or the frequency of dosage if necessary – in azotemic patients the frequency (in hours) of doses may be obtained by multiplying the serum creatinine by 9. If azotemia or oliguria occur, discontinue therapy. Mycotic or bacterial superinfection may occur.
Adverse Reactions: Irritation or pain at the injection site, skin rash, drug fever, headache and paresthesias.
Dosage and Administration: The maximum total daily dose should not exceed 15 Gm. by all routes of administration. The usual dose is 7.5 mg./Kg./12 hours I.M. The average adult dose is 1 Gm. daily. Uncomplicated infections due to sensitive organisms should respond in 24 to 48 hours.

If no response occurs in 3 to 5 days, stop therapy and recheck the bacterial sensitivities. Hydrate patients well to minimize renal irritation. Inject deeply into the upper outer quadrant of the gluteal muscle. Discard partially used vials after 48 hours. The drug should not be physically mixed with other antimicrobials.
Supplied: Rubber capped vials as a ready-to-use sterile aqueous solution in two concentrations: 0.5 Gm. in 2 ml. and 1.0 Gm. in 3 ml. Also available – Pediatric Injection 75 mg. in 2 ml.

A.H.F.S. Category 8:12.28

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NEWS NOTES

Blood Bank Training Program Receives Full Certification

The board of directors of the American Association of Blood Banks has notified Dr. Victor H. Muller, director of the Community Blood Bank of Marion County, of the full approval of the blood bank certification training program conducted by the CBB. The school is the only one of its kind in Indiana and at the present time has a quota of two students.

Donates Ancient Coins to Museum

Dr. W. L. Baughn, Anderson, has given six authentic and historically important coins to the Museum of Bible and Near Eastern Studies of Anderson College.

Nurses Hear Talk on Drug Abuse

Dr. George Teaboldt, Jr., Logansport, was one of the speakers at a recent meeting of the Pulaski County Hospital staff. He discussed the role of nurses in drug use and abuse.

Dr. James Cortese Appointed

Dr. James V. Cortese, Indianapolis, has been appointed to a four-year term on the board of the Marion County Health and Hospital Corporation.

Dr. O. M. Graves Retires

Dr. Orville M. Graves, Princeton, retired July 1 after 50 years of medical service to Gibson County residents. He opened his office in Princeton in 1927 after a five-year stay in Fort Branch. He is a senior member of the Indiana State Medical Association.

Ostomates Hear Dr. Moreira

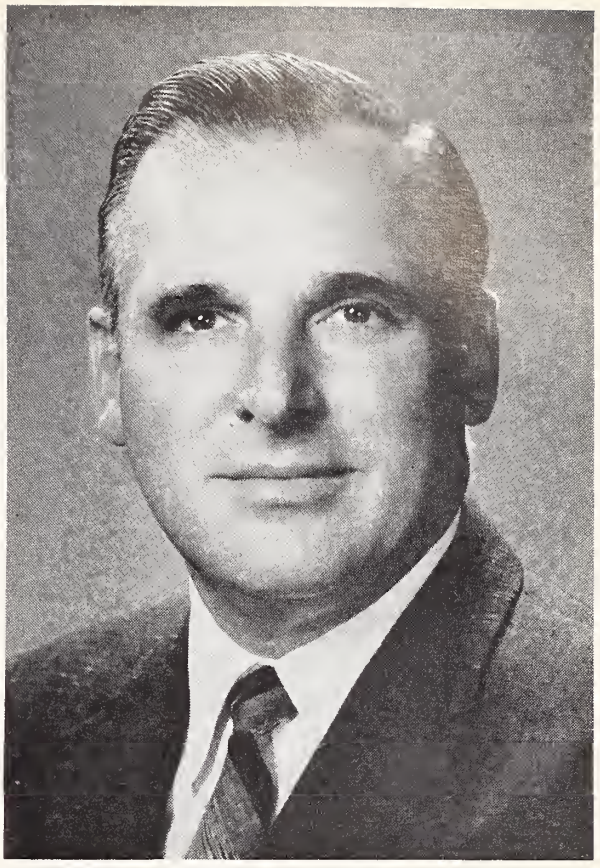
Dr. Alvara Moreira, psychiatrist and medical director of the LaPorte County Community Health Center, addressed a recent meeting of the LaPorte County Ostomy group.

Medical Staff Officers Elected

Dr. Robert Boone was chosen to serve as president of the Welborn Baptist Hospital medical staff in a recent election. **Dr. William C. Grimm** was named president-elect; **Dr. J. Bruce Cox,** secretary-treasurer; and **Drs. Larry Beisel, Alfred Lessure** and **Theodore Pavlick** were named to the executive committee. All are of Evansville.

Dr. Ray Shanks Retires

After 46 years of practice in Noblesville, **Dr. Ray W. Shanks** has retired. He is a senior member of the Indiana State Medical Association and graduated from the I.U. School of Medicine in 1925. He and Mrs. Shanks will move to Cape Coral, Fla.



DR. Donald E. Wood, Indianapolis, former president of ISMA, was elected to a three-year term on the Board of Trustees of the American Medical Association at the AMA's 120th annual convention at Atlantic City, N.J.

Drug Interaction Booklet Offered

Eaton Laboratories is reprinting again its "Guide to Clinical and Pharmacological Drug Interactions." The first two printings of 100,000 copies have been exhausted. The booklet is suitable for distribution to patients to warn about drugs in the family medicine cabinet and to remind patients to tell doctors about medicine they are taking. Physicians may obtain the booklets from Eaton sales representatives or by writing Eaton at Norwich, N.Y. 13815.

Interns Name Dr. Doran "Outstanding Teacher"

Dr. J. Hal Doran, chief of internal medicine at St. Vincent Hospital, Indianapolis, for 12 years, has been named "outstanding teacher" by the intern class of 1970-71.

"Preventive Medicine" Defined

A joint meeting of the American College of Preventive Medicine and the AMA Section on Preventive Medicine held in Atlantic City recently adopted the following official definition: "PREVENTIVE MEDICINE is that branch of medicine which has primary interest in preventing physical, mental, and emotional disease and injury in contrast to treating the sick and injured. Secondarily, it is concerned with slowing the progress of disease and conserving maximal function."

Health Planning Director Named

H. D. Offutt, Jr., M.D., is the new director of the State Comprehensive Health Planning Agency. As Director he will be responsible for implementing comprehensive health planning in Indiana.

Speaks to Heart Association Workers

Dr. H. Wayne Richmond, Columbus, was the featured speaker at a recent meeting of the Hoosier Heartland Heart Association held in Seymour.

Dr. Richmond presented his findings on a recently completed 10-year study on employees of the Cummins Engine Company regarding the prevention of cardiovascular disease.

More Hoosiers Elected, Re-elected by AAGP

Among the recently elected new members of the American Academy of General Practice are the following:

Drs. Richard R. Eggers, Crawfordsville; James B. Johnson, Greencastle; Robert L. Koenig, Valparaiso; Robert O. Lancet, Terre Haute; Frank C. McDonald. New Castle; Alfred J. Niedermayer, Evansville, and James Frank Peck, Princeton.

Others granted admission are: Drs. Thomas Neal Petry, Delphi; John Paul Salb, Jasper; Perry F. Seal, Brookville; Arthur L. Wagner, Jasper; Richard W. Wagner, Huntington; Charles O. Weddle, Lebanon; Albert T. Willardo, Hammond; Roger F. Whitcomb, Shelbyville; and Margaret Bassett, Thorntown.

Re-elected to membership in the Academy are: Drs. Berniece M. Williams, Jerome Schubert, Gerald Nolan, William Kleifgen and Clifford Curtis Smith, Fort Wayne; C. Jules Heritier, Donald B. Reid and John S. Wilson, Columbia City; James G. Bledsoe, Kenneth G. Hill and Roy G. McKee, New Castle, and M. Ali Jehanyar, Monticello.

Additional members who were re-elected recently are: Drs. Burton E. Kintner and Homer R. Swihart, Elkhart; Joseph D. Richardson, Rochester; Guy Bernard Ingwell, Knox; Catherine M. Balkema, Lafayette; Edwin Ernest Stumpf, New Haven; David B. Haggard, Plainfield; and William Stone Yocum, Gary.

Others included Drs. Richard J. Reynolds, Robert A. Schumaker and Renate G. Justin, Terre Haute; George W. Wagoner, Delphi; Gilbert H. White, Jr., and Daniel T. Ramker, Hammond; Ritchie Coons, Lebanon; Joseph W. Young, Greenwood; Philip E. Kellar, Hobart; John H. Elleman, Kokomo; Joseph Howard, Logansport; Walter J. Filipek and William J. Stogdill, South Bend; Bryce B. Rohrer, Walkerton; and Robert M. Seibel, Nashville.

Methodist Hospital Sponsors All-Day Symposium Oct. 6

The Psychiatry Service of the Methodist Hospital in Indianapolis announces a symposium on two subjects of particular significance today.

At 9:30 a.m. Wed., October 6, 1971, Dr. James Sussex of Miami, Fla., will lead off a panel discussion on Adolescence with emphasis on Drug Problems. Doctor Sussex, an outstanding psychiatrist and teacher, is the AMA delegate from the Section on Nervous and Mental Diseases.

At 1:30 p.m. that afternoon Dr. George Tarjan of Los Angeles, Calif., will lead off a panel discussion on Intellectual Deficits, Borderline States and Learning Disabilities. Doctor Tarjan has been a leader in these areas for sometime.

Among the panel members will be Dr. Ivan Bennett of Indianapolis, who is a member of the Governor's Advisory Committee on Drug Abuse, and Dr. A. L. Drew, professor of neurology with emphasis on pediatric-neurology, at Indiana University School of Medicine.

The meeting will be held in the Indianapolis Museum of Art, 1200 West 38th Street. It is open to all interested individuals with no charge for attendance. The times are 9:30 to 11:30 a.m. and 1:30 to 3:30 p.m.



DR. Guy A. Owsley, Indianapolis, was re-elected to the Council on Medical Services at the annual AMA meeting. He serves as chairman of the Council.

Pharmaceutical Manufacturers Announce $3 Million in Grants Since 1966

The Pharmaceutical Manufacturers Association Foundation summarizes its five-year experience in its most recent annual report. Since 1966 the Foundation has awarded grants of approximately $3 million to include 80 awards to medical students to familiarize them with the fundamentals of clinical pharmacology, and 19 salary support awards to medical school faculty members to extend their research and teaching capabilities. **Dr. Raymond M. Rice, Indianapolis,** is vice-president of the Foundation. **Dr. C. N. Christensen, Indianapolis,** is a member of the Scientific Advisory Committee. **Dr. Glenn W. Irwin, Jr., Indianapolis,** is a member of the Faculty Development Awards in Clinical Pharmacology Advisory Committee, and **Dr. Clyde Culbertson, Indianapolis,** is a member of the Fellowship Awards in Pharmacology-Morphology Advisory Committee.

Haver Elected IRMP Chairman

Harry T. Haver, Jr., administrator of Hendricks County Hospital, was recently elected chairman of the Regional Advisory Group of Indiana Regional Medical Program. Richard Kilborn was chosen vice-chairman and **Dr. Louis Spolyar** was re-elected secretary. **Dr. Joseph B. Davis** and **Dr. Joseph M. Black** are the retiring chairman and vice-chairman.

Dr. Wm. Kurtz Appointed Tipton County Health Officer

The Tipton County Board of Health recently announced the appointment of **Dr. William A. Kurtz, Tipton,** as public health officer. He replaced **Dr. M. B. Gossard,** who recently resigned.

Drs. Robert Haller and Jean V. Carter are members of the board.

New Booklet Available on Employee Health Testing

An informative new booklet, "How to Provide a Better Health Program for Employees at Low Cost", has been published for corporate executives and other management officials concerned with employee health, on-the-job-performance, health insurance plans, and pension and welfare fund administration.

The booklet is the first complete non-technical explanation of the new diagnostic procedure known as Automated Multiphasic Health Testing. It is available free of charge from International Compumedics Corporation, 14 Washington Road, Princeton Junction, N.J. 08550.

Legalized Abortion Panel Topic

Drs. Edward Tyler and Herbert Sedam, Indianapolis, were participants in a panel discussion held at the North United Methodist Church recently on the subject of legalized abortion.

Named to Portage Police Commission

Dr. John R. Crise has been named to a three-year term on the Portage Metropolitan Police Commission.

Dr. W. H. Shriber Wins Award

The Golden Apple Award, given annually by members of the house staff at St. Joseph's Hospital, South Bend, was recently awarded to **Dr. William H. Shriber, South Bend** obstetrician and gynecologist. The award is given for accomplishments and outstanding contributions by a staff physician.

Dr. McMeel Named Deputy Coroner

Dr. James E. McMeel, South Bend, who serves as medical director for the Bendix Corporation, has been appointed a deputy coroner. **Drs. F. Dale Nelson and Edward Shelley** also serve as deputy coroners for St. Joseph County.

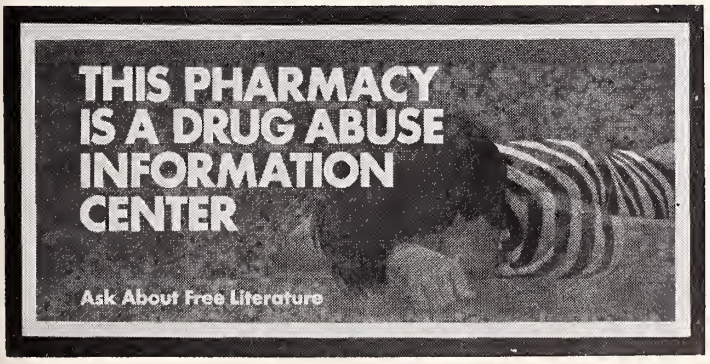
Drug Abuse Information Program Launched by American Druggists

A national education and information program to assist the nation's 55,000 drug stores in focusing public attention on the rapidly growing drug abuse epidemic in the United States was announced today by American Druggist Blue Book.

Developed in response to the growing concern of pharmacists and other health professionals over the rapidly rising incidence of drug abuse and misuse throughout the country, the Blue Book program will provide every independent, chain and hospital pharmacy in the U.S. with informational materials and promotional aids designed to help them coordinate community-wide drug abuse education campaigns.

The new program will also establish the pharmacy — a traditional focal point of health care information and service in the community — as a local clearing house for drug abuse information and as a source for referrals to agencies and organizations offering drug abuse counseling or treatment.

An extensive promotional campaign will back up the program to acquaint the public with its scope and objectives and to encourage persons seeking drug abuse information to try their community pharmacy first. Because the program complements many of the excellent drug abuse information activities of national, state and local pharmaceutical associations, the cooperation of these groups in implementing the Blue Book program will be encouraged.



THIS is the dramatic, four-color poster, suitable for window display, which will be supplied, free of charge, to each pharmacy.

Major Garry Bolinger Promoted

Major Garry L. Bolinger, a member of the Marion County Medical Society, has been promoted to chief of the Histopathology Service Branch of the USAF Medical Center at Wright-Patterson Air Force Base, Ohio, where he is currently serving as a pathologist.

Rotarians Elect Dr. W. A. Clunie

At a recent meeting of the Huntington Rotary Club, **Dr. William A. Clunie** was elected president.

BPW Club Hears Dr. Charlotte Kerr

"All About Women" was the topic chosen by **Dr. Charlotte Kerr, Michigan City,** for a speech to members of the Michigan City Business and Professional Women's Club.

Family Practice Exam Announced

The American Board of Family Practice announces that it will give its next examination for certification in various centers throughout the United States. The examination will be over a two-day period on April 29-30, 1972. Information regarding the examination can be obtained by writing: Nicholas J. Pisacano, M.D., Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Ky. 40506.

Deadline for receiving completed applications in the Board office is February 1, 1972.

Dr. Walther Named Director

Dr. Joseph E. Walther, Indianapolis, has been named director of the Digestive Disease Foundation.

Physicians Asked to Refer Patients with Paget's Disease

The cooperation of physicians in Indiana is requested in a therapeutic study of Paget's Disease of bone being conducted by the Endocrine and Metabolism Section of the Department of Medicine at the Indiana University Medical Center in Indianapolis. The purpose of this study is to determine if disodium etidronate has any beneficial effect in patients with Paget's Disease as manifested by changes in alkaline phosphatase, urinary hydroxyproline, x-ray, and alleviation of symptoms.

In order to be included in the study, the patients should be over 35 years of age, have x-ray evidence of Paget's Disease, have an elevation of alkaline phosphatase to at least twice the normal level, and have symptoms of pain and/or decreased mobility. Also, the patients should not have any concurrent chronic disease which would seriously interfere with the interpretation of results or which would decrease the possibility of the patients completing six months as a study subject.

The study will involve a four-day hospitalization and three outpatient visits over a six-month period. Results of laboratory test and x-rays will be sent to the referring physician. The study will be done at no cost to the patients who are accepted.

Physicians who have such patients that might be suitable for this study may write or telephone Dr. C. Conrad Johnston, Jr. (317-264-8554) or Dr. David M. Smith (317-264-8759), Department of Medicine, Indiana University Medical Center, 1100 West Michigan, Indianapolis 46202.

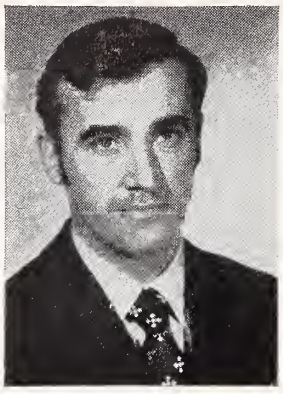
Speaks to Newcomers

Dr. Hans Geis'er, Indianapolis, was the speaker at a recent meeting of the Key to the City Newcomers Club. His topic was cancer control.

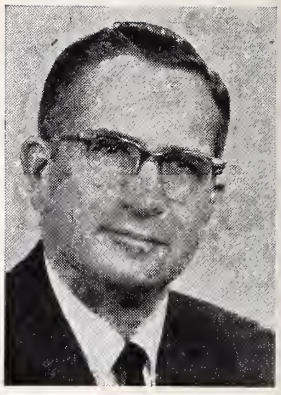
School of Medicine Names New Department Heads



Dr. Mark L. Dyken



Dr. John P. Donohue



Dr. Raleigh E. Lingeman

Three new department heads have been named to help organize the expanding programs at the Indiana University School of Medicine, according to Dr. Glenn W. Irwin, Jr., medical school dean.

The nation's largest medical school, the institution this year will accommodate more than 900 students, 273 of them in the incoming freshman class.

The new chairmen and the departments they will head are Dr. Mark L. Dyken, Neurology, Dr. John P. Donohue, Urology, and Dr. Raleigh E. Lingeman, Otorhinolaryngology (ear, nose and throat).

In announcing the appointments, Dean Irwin said all three departments have made remarkable progress during the past several years and in each case the former chairmen have asked to be relieved of administrative duties but will remain to teach.

Dr. Dyken succeeds Dr. Alexander T. Ross, Dr. Donohue succeeds Dr. Robert A. Garrett, and Dr. Lingeman succeeds Dr. David E. Brown.

OR Technicians Elect Officers

Mrs. Iris Sarvich, private surgical nurse to Dr. Harry G. Becker, was re-elected president of the Indiana State Chapter of the Association of Operating Room Technicians at their recent seminar and meeting at the Atkinson Hotel in Indianapolis. The weekend affair was attended by members and guests from the entire Midwest area, including national officers from Colorado and St. Louis. Main speaker for the Saturday evening President's Banquet was Brigadier General Thomas J. Whelan, Jr., Special Assistant to the Surgeon General for Medical Corps Affairs, Office of the Surgeon General, Department of the Army, Washington, D.C. Thirteen honorary awards were given to members of the medical profession in appreciation of their help with the organization.

Other officers elected to office were: Miss Lois Huey, Indianapolis, vice president; Mrs. Norma Singo, Madison, secretary; Mr. Lester Coats, Indianapolis, treasurer; and Miss Linda Litty, Evansville, corresponding secretary.

Appointed to Legion Service Committee

Dr. Lester Bibler, Indianapolis, has been appointed as the Indiana representative on the National Convention Hospitals and Medical Services Committee of the American Legion.

Hospital Electrical Safety Workshop Set by Medical Instrumentation Ass'n

A "Workshop on the Safe Use of Medical Equipment—Electrical Safety in the Hospital," will be held at the Airport Holiday Inn, Indianapolis, on October 4, under the sponsorship of the Education Committee of the Association for the Advancement of Medical Instrumentation. The preliminary list of faculty includes Kalman Greenspan, Ph.D., of the Krannert Institute of Cardiology; Mr. James H. Moore, Chief Electronic Engineer, Methodist Hospital, Indianapolis; and Professor Paul E. Stanley of Purdue University. To register, write AAMI, 9650 Rockville Pike, Bethesda, Md. 20014. The fees are: for members $50, for non-members $65, for students, residents and interns $20.

Elected to Royal Society of Health

Dr. Frank Green, Rushville, was recently qualified and elected as a Fellow of the Royal Society of Health, a voluntary society of England comparable to the American Public Health Association. Their Health Congress this year was devoted to pollution, environmental medicine and community health. Dr. Green attended the Health Congress as an official delegate of the Rush County Health Department. ◄

What's New?

General Electric has, for the first time, an on-line, continuous, in vivo monitor of blood/gas pC02 with a disposable sensor. Designed for use in anesthetic management, it may also be used in long-term, continuous monitoring of critically ill patients. A single arterial cannulation will provide blood samples and permit blood pressure readings.

* * *

Parke-Davis is moving into a new system of drug distribution designed especially for hospitals and patient-care centers. It is an extension of the P-D unit-dose packaging together with an electro-mechanical drug-issuing unit and an electronic data processing unit. Recent acquisition of Brewer Pharmacal Engineering Corp. makes the new system possible. The system is destined to reduce medication errors, reduce time demands, improve pharmacy control, make for more accurate billing and standardize inventory.

* * *

Environmental Sciences Associates has developed a compact single cell, electromechanical instrument that will automatically determine amounts of lead, zinc, mercury and other trace metals in medical specimens, air, water, soil, food or other materials. It is also able to analyze and record trace amounts of bismuth, indium, thallium, copper, silver and gold in quantities as sparse as 0.01 part per billion. It is small enough to be ideal for field testing.

* * *

Rachelle Laboratories announces a new dosage form—500 milligram capsules of tetracycline hydrochloride, under the name of Tetrachel-500. Tetracycline phosphate has been available in 500 mg capsules but has been much more costly than the new form.

* * *

Davis & Geck announces a new synthetic and absorbable surgical suture. It is composed of polyglycolic acid. The trade name is Dexon. It is said to possess good qualities such as handling ease, tensile strength, fray resistance, tissue compatability, and knot security in a high degree.

* * *

Doubleday released a new book recently titled *Your Religion: Neurotic or Healthy?* The author, George C. Anderson, is the founder and honorary president of the Academy of Religion and Mental Health. His book recognizes the breakdown in today's world of religious belief and practice. He discusses ways by which religion can be made more realistic and avoid the promotion of guilt and fear which often are components of mental illness; 192 pages, $5.95.

* * *

Medical Data Systems has a clinical laboratory computer system which is economical in cost. It is connected to laboratory test instruments and analyzes, calculates and transcribes all data instantaneously. Monitoring is continuous, with any deviation from standard results immediately triggering a signal. Test results are subject to visual access or may be obtained in printout form.

* * *

The Myron L Company announces a new, low-cost hand-held dialysate meter for use by both technicians and patients as a safety device to verify that the concentration of dialysate solution is the same as prescribed by the doctor. It may be used with any type of hemodialysis equipment whether in clinic, hospital or patient's home.

* * *

Doubleday has just published *The Truth About Drugs,* a book of 144 pages by Geoffrey Austrian, for the instruction of young people of junior high school age. It is written specially for this age group.

* * *

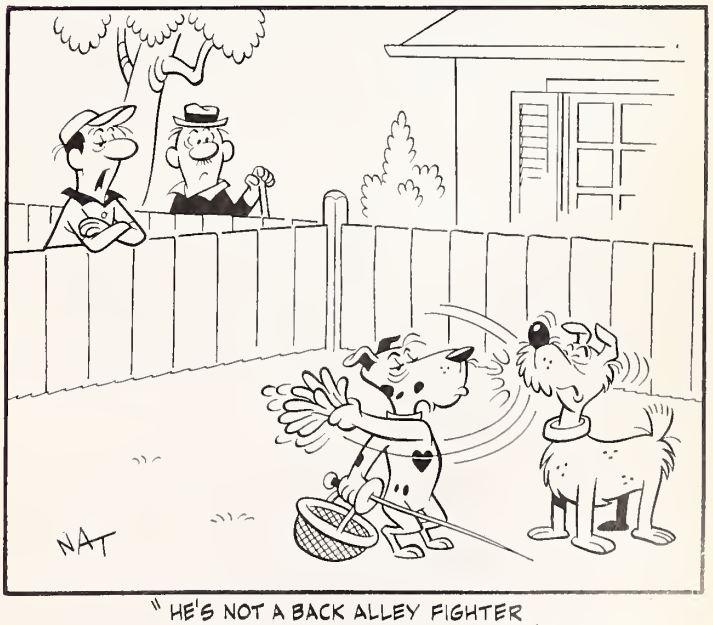
Fuller Laboratories has introduced a professional surgical dressing kit called Proct-Kit™ for patient self-care following anorectal surgery. It is packed in a compact bedside tray and includes 100 Tucks® medicated pads, one Fuller Shield® and two dispensers of sterile ARD® wound dressings.

* * *

Current Problems in Fertility, edited by Ingelman-Sundberg and Lunell of the Royal Caroline Institute of Sweden, has recently been released by Plenum Publishing Corporation. It is a collection of articles by gynecologists, biochemists, pharmacologists, surgeons and others, dealing with practical, theoretical and ethical problems related to fertilization, transplantation and contraception; 244 pages, 60 illustrations, $12.50.

* * *

Smith Kline Instruments announces a new portable, battery-operated defibrillator with cardioscope that weighs less than 25 pounds. The low cost makes it possible to stash the instrument in several locations in hospitals. Nursing homes, ambulances, aircraft, high voltage power stations and other locations should be able to afford it.



"HE'S NOT A BACK ALLEY FIGHTER LIKE JUST *ANY* ORDINARY DOG."

What's New?

American Hospital Supply has a new drape and gown fabric called "Amerilon."™ It is a non-woven material which is more moisture repellent than cloth or previous disposable fabrics. The moisture resistance is achieved with no sacrifice of necessary air permeability. The material has the feel and texture of textile.

* * *

Technicon announces an automatic system for white blood cell differential counts. Hemolab D (TM) incorporates five analytical channels to provide counts for neutrophils, eosinophils, basophils, lymphocytes and monocytes. 10,000 cells are counted in each channel, 100 times the number counted by manual methods. Accuracy exceeds manual methods.

* * *

Disposable Electrodes for establishing connection between the skin and ECG or other monitors are offered by Baxter's Travenol Division. They are lightweight, have a sturdy, one-piece construction, and eliminate the need for heavy ECG cables. Each features a 36-inch lead and a positive adhesion to provide maximum contact. They are suitable for long-term monitoring without discomfort to the patient.

* * *

An anti-skid compound, called EPOXO, is available for coating surfaces upon which people may slip and fall. It will adhere, when applied with ordinary tools, to such surfaces as concrete, aluminum, stone, macadam, and asphalt. Comes in six colors and remains bonded for as long as five years. It has strong resistance to solvents and cleaning compounds. Suitable for boat decks, corridors, shower stalls, stair treads and inclined ramps. Marketed by Epoxo Chemical Division of Falcon Safety Products.

* * *

Posey has a retractable stretcher belt which combines both strength and convenience for use on every type of stretcher and operating table. It provides needed security promptly and easily and also retracts quickly into a compact unit when not in use. It comes in both conductive and non-conductive styles.

* * *

The B. F. Goodrich Company is introducing a new latex foam hospital mattress designed for durability, easy care, and patient comfort. Tests have shown that the mattress conforms readily to the different positions of the Gatch-type bed without buckling, bending or breakdown. The latex foam contains millions of tiny air cells to contribute flexibility and light weight.

* * *

Doubleday's recent publication of *A Second Birthday* by William Stringfellow has been announced. The book is a personal account of the author's experience with a baffling and apparently hopeless disease which was cured by a last-ditch type of operation. The price is $5.95.

A combination of the technology of color television and the gastro-fiberscope by Toshiba International has resulted in a new tele-endoscope. The optical properties of the flexible fiberscope enables the production of a large image in full color on a viewing screen. Lesions as small as 2 mm in diameter may be visualized.

* * *

Posey has a new combination foot and body cradle. It may be attached to any standard hospital bed. It is designed to keep the weight of sheets and blankets off the body or feet and also may be used with the Posey Foot Support to help prevent footdrop. The patient may move freely without restriction with plenty of room between himself and the cradle.

* * *

Doubleday announces publication of a book which chronicles the experience of two people who face death together. It is written by Prince Leopold of Loewenstein as a final tribute to his wife Diana during her last illness. "A Time to Love . . . A Time to Die . . . unforgettable narrative of love and sorrow and triumphant faith"—Norman Vincent Peale. 288 pages, $6.95.

* * *

Stryker is introducing the Emergency Room stretcher as part of its Modular Stretcher System. The interchangeable Fowler litter top of the ER stretcher permits transfer of patients to other specialized Modular Stretchers. Accessories on ER stretchers include a center steering wheel for easy maneuverability, swing style side rails, folding or portable I.V. rods, personal effects basket and oxygen and drainage bottle holders.

* * *

Derma Surgical, the 3% hexachlorophene antibacterial scrub, is now being marketed under the name hyper**pH**aze. S. M. Edison Company, which is a subsidiary of Colgate-Palmolive, also makes Dermassage Lotion, and packages this and Colgate toilet articles in hospital admission kits. Hyper**pH**aze is considered a more suitable name than Derma Surgical because it is formulated to maintain its pH between 4.5 and 5.5 when mixed with water. This enhances the antibacterial activity.

* * *

The Picker Corporation introduces the first Ultrasonoscope designed specifically for cardiac examinations. Its capabilities include determinations of the extent of fluid in pericardial effusion, degree of mitral stenosis, size of left atrium, and the internal diameter of the left and right ventricle.

* * *

Dictaphone has a new low-cost automatic telephone answering system which uses tape cassettes. The Ansafone Model 540 will sell at the suggested retail price of $275. It will answer an unattended phone, play a pre-recorded message to the caller and record caller messages.

*something to have and hold on to



*Blue Cross and Blue Shield bring the thought behind the membership card up front

Something to have and hold onto—a simple and caring thought behind the members' identification card.

Its meaning to you:

Something to have in these days of wondrous but expensive medical progress.

Something never to give up.

Something comforting, something to hold onto when you feel all alone facing the prospect of costly health care bills.

More than two million Hoosiers have faith in these health care plans. They know for sure that the Blue Cross and Blue Shield membership card is indeed something to have and hold onto.

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®American Hospital Association ®'National Association of Blue Shield Plans

(One of a series of ads being run in key Hoosier newspapers)

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Broad product selection — travel trailers, truck campers, motor homes, travel homes. Over 50 model variations — compact and spacious sizes with a wide price range. Exciting decor options. Manufacturing experience — over a quarter century. Extra value — each model is designed to comply with nationally approved standards and craftsmanship excellence. See the "Big ONES" for '71 — FRANKLIN!

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County, District News

Seventh District

The annual meeting of the Seventh District Medical Society was held June 2 at the Martinsville Country Club, and the following officers were elected:

President, Dr. John M. Records, Franklin; president-elect, Dr. Donald F. Stephens, Indianapolis; and secretary-treasurer, Dr. Merrill M. Wesemann, Franklin.

Dr. John Butler, Indianapolis, was elected trustee to succeed Dr. James Gosman, while Dr. Joseph F. Ferrara, Franklin, will fulfill the unexpired term of Dr. Butler as alternate trustee.

Allen

Dr. Kenneth F. Isenogle will serve as president of the Allen County Medical Society for the coming year, with Dr. Richard B. Juergens serving as secretary. Both are of Fort Wayne.

Hendricks

Dr. Glenn Baker, Brownsburg, is the new president of the Hendricks County Medical Society. Dr. Mark N. Folkening, Plainfield, is the vice president, and Dr. Donald Cheesman, Danville, will serve as secretary-treasurer.

Lawrence

Dr. James L. Mount, Bedford, has been named president of the Lawrence County Medical Society for the ensuing year.

Marion

Dr. Arvine G. Popplewell, medical director of Marion County General Hospital and assistant dean of the medical center of Indiana-Purdue University, Indianapolis, became the 97th president of the Marion County Medical Society September 1, succeeding Dr. Donald E. Stephens.

Dr. A. Alan Fischer was named president-elect. Also elected were Dr. Malcolm Wrege, vice-president; Dr. Charles R. Thomas, secretary-treasurer, and Dr. Ralph U. Leser, library committeeman. New members of the board of directors are Drs. Warren E. Coggeshall, George T. Lukemeyer, Victor H. Muller, Robert F. Nagan and John J. Pantzer. Drs. Richard A. Brickley, Joseph M. Daly and I. E. Michael were elected to a second term on the board.

Owen-Monroe

New officers chosen by the Owen-Monroe County Medical Society are: President, Dr. Glen D. Ley, and secretary, Dr. James Ray, both of Bloomington. ◄

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—July 1971

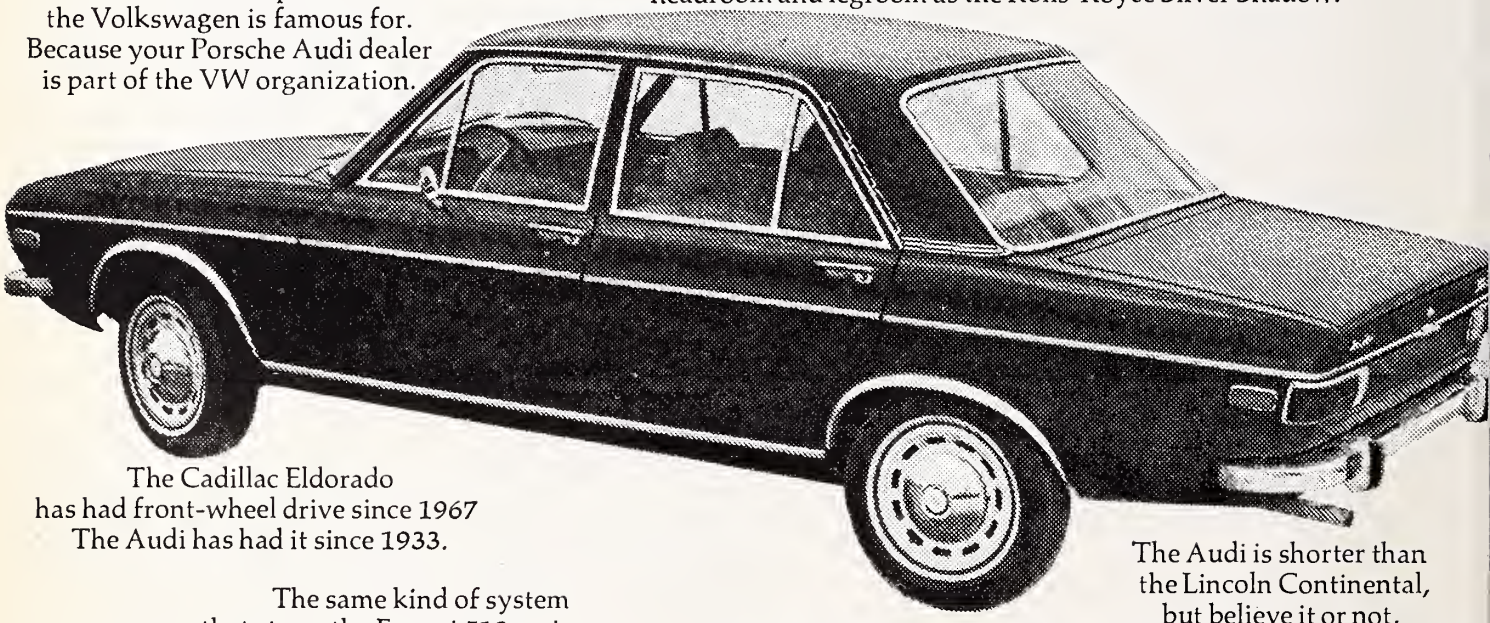
Disease	Jul. 1971	Jun. 1971	May 1971	Jul. 1970	Jul. 1969
Animal Bites	1445	1467	1210	1470	1408
Chickenpox	96	300	357	36	105
Conjunctivitis	282	171	218	157	150
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	46	28	20	26	25
Gonorrhea	834	522	527	824	707
Impetigo	176	75	79	171	212
Infectious Hepatitis	42	39	68	45	32
Infectious Mononucleosis	42	53	115	44	33
Influenza	820	351	810	206	237
Measles					
Rubeola	135	559	720	22	14
Rubella	103	520	437	77	75
Meningococcic Meningitis	1	1	7	0	1
Meningitis, Other	6	5	6	3	3
Mumps	150	510	837	103	99
Pertussis (Whooping Cough)	13	3	9	15	9
Pneumonia	286	257	295	209	173
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	580	577	724	455	416
Syphilis					
Primary & Secondary	44	25	28	38	33
All Other Syphilis	125	87	83	170	117
Tinea Capitis	0	1	0	1	8
Tuberculosis (Active)	60	58	99	102	81

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BOARD OF TRUSTEES

June 13, 1971

The Board of Trustees of the Indiana State Medical Association convened in the Headquarters Building on Sunday, June 13, 1971, with Dr. Joe Dukes, Chairman, presiding. The meeting was called to order promptly at 8:30 a.m.

Roll Call

District	Trustee	
1	G. M. Wilhelmus	Present
2	Joe Dukes	Present
3	Eli Goodman	Present
4	Robert Reid	Absent
5	Wilbert McIntosh	Present
6	Stephen Smith	Present
7	Dwight Schuster	Present
7	James Gosman	Present
8	Richard Ingram	Present
9	William Sholty	Present
10	Vincent J. Santare	Present
11	Lowell Hillis	Present
12	William Clark	Present
13	Otis R. Bowen	Absent

Alternate Trustee

1	Raymond Newnum	Absent
2	Betty Dukes	Absent
3	E. L. Wallace	Absent
4	Jack Shields	Present
5	C. M. Schauwecker	Present
6	Paul Inlow	Present
7	John O. Butler	Present
7	Joseph Kerlin	Absent
8	Robert Williams	Absent
9	Lindley Wagner	Absent
10	Thomas Tyrrell	Present
11	James Harshman	Present
12	Frederic Schoen	Absent
13	G. Beach Gattman	Present

Officers:

Malcolm O. Scamahorn, President	Present
Peter R. Petrich, President-Elect	Present
Lester H. Hoyt, Treasurer	Present
Hugh K. Thatcher, Assistant Treasurer	Present
Frank B. Ramsey, Editor *The Journal*	Present

Executive Committee:

Donald M. Kerr, Chairman	Present
Wilbert McIntosh, Member	Present

Delegates and Alternate Delegates to AMA:

Don E. Wood	Present
Eugene F. Senseny	Present
Frank H. Green	Present
John S. Farquhar	Present
Jack Shields	Present
James A. Harshman	Present
Eugene S. Rifner	Present
K. O. Neumann	Absent
P. J. V. Corcoran	Present
T. C. Tyrrell	Present

Guests:

Glen W. Irwin, Dean I.U. School of Medicine	Present
J. M. Black, Chairman Blue Shield Board	Present
Guy A. Owsley, Chairman, AMA Council on Medical Service	Present
Andrew C. Offutt, Secretary, Indiana State Board of Health	Absent

Staff:

Robert J. Amick	Present
John Walters	Present
Jas. A. Waggener	Present
Howard Grindstaff	Present
Kenneth W. Bush	Present

Minutes of Meeting March 28, 1971

The minutes of the meeting held March 28, 1971, were approved on motion of Drs. Petrich and Wilhelmus with an editorial change.

Report of the President

District meetings, generally were much better attended than in the past, I think. This is encouraging and I want to thank the districts for cooperating with the staff and with the district officers. I believe the subject matter was much better than usual and I believe this accounted for the good turnout.

I am going to ask for five minutes of additional time on the agenda to be given to the SAMA representative, Miss Jane Henny.

Report of the President-Elect

I would like to introduce Dr. Howard Jackson from Madison who is the new alternate trustee from his district.

Having missed the last meeting and not having had an opportunity to talk with you, I decided I should give you a complete report at this time.

I would first like to touch on a meeting in Milwaukee of the State Medical Society of Wisconsin. There were several things which I thought were very interesting and worthy of the consideration of this Board and perhaps our House of Delegates. They have a nominating committee, which I had never seen work before at the state level. It is composed of a representative from each of their Councilor districts. They held an open meeting for one hour, during which time the candidates or representatives of the candidates appeared before the nominating committee and made their presentation.

The meeting is open to the representatives of the candidates, the speaker of the House, the vice-speaker, the president-elect, the AMA delegates and their alternates. At the end of the hour's time the nominating committee goes into an executive session and then makes their report to the House of Delegates, its slate of candidates for the offices to be filled. Many times there is not just a candidate—sometimes they pick more than one for the office and the House then decides. It cuts down the time involved during the meeting of the House during which the election takes place by cutting out the nominating and seconding speeches. When the chairman makes his report, it is seconded by someone from the floor and if there are no other nominations from the floor it moves the election procedure along rapidly and it is something we might like to consider.

Another thing they have is a Speaker of their House of Delegates. We have talked about this before on many occasions and it is amazing how much parliamentary procedure can be handled from the chair when someone does this on a regular recurring basis. To me, it appeared that the meeting moved along at a much more efficient clip.

I would propose to you that some consideration be given to this prior to the meeting of the House of Delegates this fall.

Perhaps something should be done concretely in this direction by this association.

The next item is that they have three sessions of the House of Delegates. The first session on Sunday, the second session on Monday and the last session on Tuesday. The Sunday session was held in the afternoon, followed by Reference Committee meetings which continued on Monday morning, if necessary. At the end of the day there was enough time for the Reference Committee reports to be reprinted so that on Monday night they had their long session. On Tuesday morning, starting at about 10 o'clock, they had a third session for the election of officers, the emergency resolutions, etc., which took perhaps an hour to an hour and a half and the business of the House of Delegates was completed within a period of 48 hours. It certainly showed how in contrast some of our sessions coming the last day have carried over until six or seven o'clock at night. I think we should seriously consider streamlining and better utilizing our time and this I would again like to offer for your consideration and study.

The next item is the report on the Foundation for Medical Care meeting recently held in Chicago, which you decided I should attend. This was sponsored by the

Department of HEW and by the Foundation itself, which is an organized group, and the states represented were: Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Mississippi, Nebraska, North Dakota, South Dakota, Ohio and Wisconsin.

The speaker from Minnesota said that, because of the criticism they had received concerning people not getting care, they decided to establish a Foundation which has now been operative for 22 months. He reported they have had lots of problems and they are going through what he calls "growing pains" but they seem to be delivering health care at a reasonable prepaid price on a fee-for-service basis. I gained the impression these Foundations were not delivering a complete health care package, such as envisioned by the government. It appears, however, the people with whom they are dealing are getting reasonable care and the doctors are getting reasonable compensation for their service and it was reported it was working nicely to all those concerned.

Over the period of two days there were mostly specific problem areas, such as University students, etc. The migrant worker was another problem. I felt one of the most important parts of the two-day session was the Medical Program which is a direct welfare program in California. The other programs described are apparently all relatively successful. The Medical Program, however, is only paying approximately 40¢ to 50¢ on the dollar to doctors, hospitals, and other providers of health services. In order to make any kind of workability of the program it was necessary to force the California state government to hire its own full-time physician administrators to determine the eligibility of the individuals under the program and to permit by voucher on a regular basis the patient's trips to physicians and hospitals. The voucher must be given to the individual prior to the service being rendered. Remember, these patients must apply for emergency vouchers and I cannot conceive how anybody could realize that they are going to have an emegency tonight or tomorrow. Apparently the program in California has become this ridiculous.

Other programs discussed were CHAP, which is the Certified Hospital Pre-Admission Program, which is now in operation in the Sacramento Foundation and which involves pre-admission testing of the patient to decrease the length of stay in the hospital and it seems to be working successfully. The cost of the pre-admission testing averages approximately $11 per patient but they claim the cost saved through the decreased time in the hospital will have amounted to more than a million dollars on Medicaid patients alone in one year's time.

One thing about it which is interesting is that there is a nurse coordinator who correlates the length of stay of the patient with the illness and she is responsible and specially trained for informing the patient they have only so much time allowed in the hospital. For example, if they are in for a gall bladder removal, they are allowed six days hospitalization and the nurse coordinator at the time of admission to the hospital prior to surgery tells them of this restriction. If there is some unusual or extraordinary circumstance involved in the care of the patient, the nurse coordinator contacts the Medical Director and makes the necessary changes, in the allowable hospitalization time. I gathered that while it may be working, there was criticism from physicians about a nurse taking on a job such as coordinator.

The last item which was discussed was PSRO, PRO and HMO. The Foundations by and large won't qualify as HMOs and that is a point I would like to make. In some of my conversation I have the feeling there is discontent by some of those in HEW because of the failure of the administration to be exact about what they are proposing and how they plan to proceed. I think that we tend very often to accept a very vague non-specific suggestion on the part of the government with nothing concrete when really the government is turning the tables on us and picking our brains about what kind of care we could give and how much we could do it for, etc.

The next meeting which I attended was a waste of my time and your money. I am sorry to say. It was put on by HEW and had to do with the Health Maintenance Organization. HMO is defined as an organized system of health care which accepts the responsibility to provide for or otherwise assure delivery of complete comprehensive health services. They explain that these services are provided through a voluntarily enrolled group and "voluntarily" is a part of the verbiage. Reimbursement for services takes place through a pre-negotiated fixed schedule through period payments. They point out the four ingredients are the essential things. (1) Organized system (2) comprehensive care (3) Voluntary group (4) Fixed payment. There are apparently no other rules and regulations that are specific on these points.

In this Chicago meeting we heard from a Ph.D. in physics who told us how we could deliver health care. We heard from attorneys from the Department who were telling us what was wrong with the system of health care and health care itself in this country and we heard from everybody and his brother but heard only from one physician. Minority groups shouted down many from the audience who attempted to stand up and make a valid point. There was no opportunity for discussion. In my opinion, it was not a conference. It was a brainwashing session.

Discussion

Dr. Santare: Why do not Foundations qualify for HMOs?

Dr. Petrich: Primarily, and this is not an administrative reason, this is the reasoning from the Foundation people themselves, primarily they have no direct ties with hospitals. Under the HMO concept he must provide for comprehensive care, including hospital, and the Foundations merely have an insurance program to provide for hospitalization.

Dr. Gosman: I would not like to let two thoughts that Dr. Petrich brought up die without action. First, the question of a Speaker of the House and second the question of streamlining the annual meeting.

I would therefore like to move that these two items be given to our Commission on Constitution and Bylaws for study and report.

The motion was discussed by several, duly seconded and carried.

Streamlining of Annual Meeting

Dr. Santare: I move that some committee of this body, between now and October, study the streamlining of the agenda for the state meeting with the aim of possibly improving our agenda and report back by October of this year so that we can plan for the following years.

Chairman: Do you want an Ad Hoc Committee?

Dr. Santare: Yes.

The motion was duly seconded, put to vote and carried.

Chairman: I will appoint Dr. Santare, Chairman; Dr. Paul Inlow and Dr. Eli Goodman.

Comments of Miss Jane Henny

Dr. Scamahorn: The SAMA group was very active and we have as our guest, Miss Jane Henny from Woodburn, who is a Junior. She has been particularly interested in the MECO project, which we approved last year and she will report on as well as the general activities of the SAMA organization and will be happy to field any questions you have.

Miss Henny: I think first of all I would like to talk about the MECO project, since that is what I have mostly been involved in this past year. I would also like to thank this Board for the support which you have given us in our MECO project. MECO, in Indiana this summer has seven hospitals participating. These seven hospitals are offering nine positions to students and these are students which have just completed their pre-med program and will be going to medical school this fall or have completed their Freshman year and will be enrolling as Sophomores next year. We have 55 students who have indicated that they have subscribed for this additional education, so there is a great deal of student interest.

At the national level, MECO is currently going through an evaluation process of activities at both the state and national level. We will be getting their report at the end of the summer which will show us just where we are as far as MECO is concerned. I would again like to thank you for your help in this project.

The Indiana Chapter of SAMA in general has increased its activities and right now is doing an in-depth evaluation of students to determine what projects they are concerned with and this will be used as a basis for establishing new goals for the coming year to get more students actively involved in our Chapter.

The report of Miss Henny was discussed by many and several questions were asked concerning the MECO project.

Report of the Treasurer

Dr. Hoyt: All of you have received the printout from our computer people. I believe each of the pages is self-explanatory.

Following a brief discussion of the report, on motion of Dr. Hoyt and Dr. Gosman, the treasurer's report was approved.

Editor of The Journal

Dr. Ramsey: The figures show *The Journal* in the black at the present time but this will not persist for very long. Our advertising revenue is less in the summer. We have two large issues—June and September—and the printing bill is going to be large, so therefore I feel that we should not be nervous about being in the black.

We have a request from the Academy of Ophthalmology and Otolaryngology. In the past they have published their own transactions, totalling annually about 250 copies, of their scientific papers and they have requested *The Journal* to consider the possibility of publishing these scientific articles in *The Journal*, either as a special issue or scattered throughout the year. There are some considerations in a question like this. First, of course, is that the state association is anxious to be friendly and kind to all specialty organizations and to help them all we can. The scientific papers which are read at a specialty meeting are of great interest to the specialists but are not written and should not be written for general consumption. *The Journal* is always delighted to select papers which would be of interest to all facets of the medical profession. If we were to accept this offer, it would be a precedent which might later involve other specialty organizations, and, while we have accepted specialty papers given before specialty groups, we have never accepted all the scientific output of any one specialty organization.

Mr. Waggener and I thought this was a proper matter for the trustees to decide, since it is a matter of policy and precedent and I would like to submit it to you at this time for your action.

The matter was discussed by Dr. Harshman, Dr. Ramsey and Dr. Wilhelmus.

Dr. Wilhelmus: I note on the sheet which has been passed out in this meeting that general practitioners comprise approximately 33% of our membership—roughly that leaves 66% specialists, and I therefore move that the Board permit Dr. Ramsey to proceed to figure out the cost of adding these transactions in *The Journal* with a small profit of 5 or 10% to be paid for by the specialty organization. If this is acceptable to the specialty groups, maybe more specialty organizations will use *The Journal* for this purpose and maybe more people will read it.

The motion was duly seconded by Dr. McIntosh, put to vote and carried.

Reports of Trustees

District 1

Dr. Wilhelmus: I would first like to thank our president, Dr. Scamahorn, and our field representative, Mr. Amick, for attending our meeting. We had an excellent meeting. I was reelected trustee for another term.

District 2

Dr. Joe Dukes: I am going to let Dr. Scamahorn make my report for me.

Dr. Scamahorn: The 2nd District had a good meeting and Dr. Dukes was re-elected Director of Blue Shield. The meeting was very well attended and I think everyone had an excellent time. Dr. Brown was given an award for having served as secretary of the 2nd district for 50 years. He was very pleased that they recognized him. He is very energetic even after 50 years of service.

Dr. Joe Dukes: Dr. Brown completed his forty-ninth year and was re-elected to his fiftieth. Dr. Betty Dukes was elected alternate-trustee.

District 3

Dr. Goodman: Our annual meeting was held in New Albany during the period of time when the state legislature was in session. The attendance was very scanty. Dan Cannon was re-elected president of the district; Dr. McCalla was re-elected secretary and Dr. Neathamer was elected alternate trustee. The program consisted of a physician-wife combination who talked on "Sex Education" and invited to the afternoon session were some school people and other interested individuals who outnumbered the physicians at the scientific session.

There was some feeling that we were going to have to do something different than we have been doing to improve our district meetings. A committee consisting of Dan Cannon, John Paris and myself are to meet later and try to explore what our problems might be, in order that we may stimulate better attendance in the future.

Chairman: Dr. Goodman, would you remember to report to the Board the findings of your committee?

District 4

Dr. Shields: At our district meeting I was elected the trustee and Dr. Jackson of Madison, alternate trustee. The scientific program consisted of a discussion on "Coronary Care" and the attendance at our meeting was fair.

District 5

Dr. McIntosh: Our meeting was held on the 14th of May at the Terre Haute Country Club. In the afternoon there was a business meeting which many dignitaries attended, including the president-elect, and the chairman of the Board.

We also discussed improving attendance and our approach to this, which I think is significant for our area, is that we have made $10 dues for our district meeting which includes their dinner. We are going to try this and see if it does help attendance. Dr. Wakiem was the speaker for the evening. The next meeting will be held May 24, 1972.

District 6

Dr. Smith: We had our meeting in May which was attended by Mr. Waggener and Dr. Petrich. We had a scanty meeting.

Dr. Mark Smith of New Castle was elected president; Dr. John Moenning of Greenfield was elected vice-president; and Dr. Tower of Shelbyville the secretary-treasurer. Mr. John Pont, the I.U. Football Coach was the after-dinner speaker.

District 7

Dr. Gosman: The district met at the Martinsville Country Club on June 2nd. Dr. John Records of Franklin was elected president; Dr. Don Stephens, president elect, and Dr. Merrill Wesemann was elected the secretary-treasurer. Dr. John Butler was elected trustee of the 7th district to succeed me, and Dr. Joseph Ferrara of Franklin was elected alternate-trustee. At our meeting we got a little hot on the subject of Blue Shield which primarily concerned the statement that was sent out concerning the explanation of benefits.

It was moved that instead of "fee not allowed," the wording "Not covered by" be substituted.

The speaker was Dr. Raymond Murray, director of the Regenstrief Foundation who spoke on "What's New in the Health Care Delivery System." Our next meeting will be held in Franklin on June 14, 1972.

At this time, Mr. Chairman, if it is proper, I have a letter from the Marion County Medical Society requesting that the dues of Dr. Maurice H. Mentendiek be waived due to illness. I so move. The motion was seconded by Dr. Scamahorn and carried.

I have another letter from the Marion County Medical Society requesting that the dues of Drs. Archie E. Brown, Laura Hare, Hugh E. Martin and Dan E. Talbott also be waived, due to retirement from active practice, and I so move. The motion was seconded by Dr. Scamahorn, put to vote and carried.

I also have a request that the dues of Dr. Judith Edwards be waived as she is not engaged in the active practice of medicine, and I so move. The motion was seconded by Dr. Schuster and carried.

Marion County also requests that the dues of Dr. John M. Young be waived; he is being classified as a retired member since he is no longer engaged in the active practice of medicine. I so move. The motion was seconded by Dr. Scamahorn and carried.

I would also like to report that Mr. Loftin, our executive secretary, has just returned from Washington where he attended a briefing on just what is going to be done as far as Indianapolis having been chosen as one of the cities to set up a model program or to study the program for health care systems. I think over a million dollars has been allocated to this committee and, as I understand from Mr. Loftin, this will be run through the Comprehensive Health System so that Marion County Medical Society will have a voice. We are studying all these matters and will keep you posted on developments.

District 8

Dr. Ingram: We had our meeting at the Portland Country Club on Wednesday, May 26. Dr. Petrich was in attendance, and Dr. Frank Beeler was elected president and Edward R. Rush the secretary-treasurer. The evening meeting featured a talk by Dr. Campbell whose subject was "Detection of Coronary Artery Disease" which was very interesting. The wives asked him a lot of questions about how they should feed their husbands. The program was enjoyed by all.

District 9

Dr. Sholty: We tried something different this year in an effort to stimulate attendance. Hamilton County was the host society but we held the meeting in Lafayette. We had 20 at the scientific session, which was on the subject of "Diabetes". The speakers were Dr. James Vance and Dr. Charles Clark of the I.U. Medical Center.

Dr. Max Hoffman of Covington was elected alternate trustee and Boone County will be the host next year and the president of the district will be the president of the host county. The dinner meeting was held at the Country Club and Dean Earl Butz of Purdue spoke on "Practical Ecology" and we had a trio from the Purdue group as entertainment.

District 10

Dr. Santare: The 10th district met on June 2nd at Lake Hills Country Club and there was golf in the afternoon. We had no scientific session. There was a Lake County Medical Society Meeting in which amendments to the Constitution and By-laws were read for the second time and adopted. Entertainment was furnished by some Greek dancers from the Island of Crete. I was reelected trustee.

District 11

Dr. Hillis: The 11th district will meet on September 15 at the Mississinewa Country Club in Peru. We are meeting this week to arrange the program. We always have a big crowd and a good program.

District 12

Dr. Clark: Our district met on May 19 in Fort Wayne. George Manning was reelected president; Frank Bryan, vice-president; and William Hughes was reelected the secretary-treasurer. Dr. Walter Greist was elected alternate trustee. We had a little trouble with attendance but we had a pretty good meeting. There were about 100 out but this is not what it should have been. I have suggested that we change the meeting date to later in the year. It has been about the third Wednesday in May. We would like to submit the name of Dr. Arthur F. Hoffman as a candidate for the physician of the year award. We would also suggest Carol Shackleford for the Journalism award, and Dr. David Gastineau is our candidate for the Governor's Commission on Higher Education.

District 13

Dr. Gattman: Our meeting was scheduled for September 2 and I do not have the program at this time.

Chairman: I would like to compliment the staff for getting our agenda out early so that everyone had time enough to read it. This is a big help.

Matters Referred by Executive Committee

Dr. Kerr: The Executive Committee met yesterday and considered some 60 items. The following we refer to the Board:

The first matter relates to two resolutions which we would like to present to the AMA in June. These resolutions deal with objections to the substitution of drugs.

On motion duly made and seconded, the resolutions were referred for submission to the AMA House of Delegates.

The next item is a vacancy on the Blue Shield Board caused by the death of Dr. G. O. Larson. We need some one to nominate to fill his unexpired term which expires in March of 1972.

Chairman: I suggest we defer this until we have our report from the Ad Hoc Committee on Blue Shield. The motion was duly made to defer this matter until the report from the Ad Hoc Committee is received.

Dr. Kerr: The next is a letter received by our secretary from a Clinic in Indiana which expresses an interest in developing a prepaid service plan in their area and asking if there would be any objection on the part of the Indiana State Medical Association. Mr. Waggener has replied that he knew of no action on the part of the association which would indicate there would be objection; however, this matter would be referred to the executive committee at their next meeting. Are there any comments or do you feel there should be objections?

Dr. McIntosh: I move that we leave it as it is. The motion was duly seconded and carried.

Dr. Wilhelmus commented that he was aware that this was going on but he thought that, as a matter of information, the trustee of the district involved should be sent a copy of the letter together with any reply from the state office.

Dr. Kerr: The next item is a letter of appreciation from Mrs. G. O. Larson for the remembrance of Dr. Larson by the

association.

A motion was duly made and seconded that Mrs. Larson be written a letter expressing the feeling of the officers of the association that she is welcome at all meetings of the association and urging her to attend.

Dr. Kerr: The next is a report from the Commission on Medical Economics and Insurance. One is on the parameters for Medicare and Medicaid services. As you recall, Blue Shield issued a dictum, and I use the word in every sense you can imagine, relative to what they will or won't pay for in the care of patients. This was referred by this Board to the Commission for study and expression of their opinion and we have received the following report:

"The Commission considered the parameters for Medicare and Medicaid service as presented to the Board of Trustees by Blue Shield and found the parameters to be completely unacceptable. The Commission recommends to the Board of Trustees that they inform Blue Shield that these parameters are entirely unacceptable to the Indiana State Medical Association and to the Indiana State Medical Association members. If Blue Shield had evidence of irregular medical practice, it should present such information to the proper medical authorities and not presume that there are irregular practices. Such parameters are restrictive and not conducive to good medical care. K.N., Chairman."

The matter was discussed by several and motion was duly made and seconded to accept the report of the Commission.

The motion was further discussed by many.

The motion was then made to amend the original motion that this report not only pass but be forwarded to Blue Shield as a matter of information to them.

Chairman: Directly or through the liaison group?

Comment

I see no reason not to send it to them directly.

Dr. Kerr: The chairman reminds me there is a meeting between the Executive Committee of ISMA and Blue Shield for 1 July. Is it set up?

The motion to amend was duly seconded and further discussed.

Dr. Kerr: I will read to you, for your memory, the previous action on this same matter. "Dr. Scamahorn. I move that we accept the report of Blue Shield and accept in principle the parameters as presented on Medicaid Services and send them to the Commission on Medical Economics and Insurance for recommendation and follow through as amended."

Dr. Schuster: The Commission says they don't like it, so I move we accept the report.

Dr. Thatcher: I agree with Dr. Ingram, that it should not be referred to them by letter which they can stop and give you a good hash answer on and let it go at that and it can either be referred to the Executive Committee, as arranged, or back to the Commission and go to them and argue the point.

Dr. Ingram: I would point out that my amendment would not preclude the Commission from approaching them. The only thing is, it has been my experience that it takes one, two or three months for these meetings to take place. In the meantime, they are going on and developing the machinery to do what they want to do anyway and I would like for them to know immediately that we are opposed to this.

Chairman: In the interest of time, let us review what we have done. We have a motion to accept the report from Medical Economics and Insurance which has been seconded and a motion to amend the original motion that this not only pass but be forwarded to Blue Shield as a matter of information to them voicing our objections to the parameters. The question is on the amendment to the motion.

The question was called, the motion to vote and the amendment was adopted.

Chairman: The question now is on the original motion as amended. The amended motion was put to vote and carried.

Dr. Kerr: The next item relates to the difficulty experienced in some areas in having the assistant surgeon paid by insurance carriers. Some contracts apparently state that where there is a resident or intern available no fee will be paid for the assistant surgeon.

This matter was referred by the Executive Committee to the Commission on Medical Economics and Insurance and I will read their opinion to you. "In accordance with policies established previously by Indiana State Medical Association, we move the assistant surgeon should be compensated for his services regardless of whether an intern or resident might be available as an assistant. Payment should not be made to an intern or resident for providing assistance in surgery".

The matter was discussed by Dr. Schuster, who pointed out that the Board of Marion County Medical Society had discussed this same matter and had informed the insurance carrier that they would not accept this program in Marion County.

Dr. Santare commented that assistant's fees are still being paid by insurance carriers in Lake County such as Blue Shield, Equitable and Republic Steel groups.

Dr. Kerr: The next matter referred to the Board is a letter from the State Welfare Department directed to various county departments listing the consumers who have been declared persona non grata. This was taken as a matter of information.

Dr. Kerr: The next matter the Executive Committee calls to your attention is the letter relative to vacancies on the AMA Councils and Committees. All of you, I understand, have previously received a copy of this information. The Executive Committee reviewed these vacancies and came up with these recommendations which we submit to you for your acceptance, alteration or deletion.

Council on Health Manpower, Dr. P. J. V. Corcoran, Evansville; Council on Legislation, Dr. Dwight W. Schuster, Indianapolis; Council on Aerospace Medicine, Dr. Thomas Johnson, Indianapolis; Committee on Occupational Toxicology, Dr. Robert Forney. With respect to Dr. Forney, it was pointed out that he is a Ph.D., but if you will notice on the listing sent from the AMA, the individual who is going off this council is a Ph.D. The Council on Scientific Assembly, John Ferry of Lake County. Committee on Exercise and Physical Fitness, Dr. Brad Bomba of Bloomington. Committee on Medical Aspects of Sports, Gilbert Wilhelmus of Evansville; and Committee on Medicine and Religion, Burton E. Kintner of Elkhart.

We do not have suggestions for any of the other spots and if there are no objections from the Board, we will submit the names that we have read to you in this report. A suggestion was made that the name of Dr. Isaac Michael of Indianapolis also be submitted as a possible nominee for the Council on Aerospace Medicine.

Dr. Kerr: The next matter referred to the Board is a letter from the Governor's office regarding the Commission for Higher Education. Each of you has received a copy of this letter together with the qualifications for the nominees and, while the nominees need not be physicians, it was felt that perhaps you might have some person in your area whom you would like to nominate to this new commission. We would urge the Board members if you have any nominees for this commission to get them in today or no later than the end of the week.

Dr. Kerr: The annual convention is again before us and, as you may recall, the Executive Committee recommended that there be a sum of $1500 to be used for paying speakers in the scientific sessions. This the Board approved. The association has received a communication from Dr. Ferry and Dr. Waife of the Convention Arrangements Commission outlining the speakers who will appear be-

fore the convention this fall and estimating their cost of travel and housing, stating that the bare necessities for their expenses would be $2,576, and they felt that $1500 was woefully inadequate. They would like your opinion as to what appropriation should be made for this purpose.

It was moved that the committee be allowed up to $3500 for this purpose. The motion was duly seconded, put to vote and carried.

Chairman: I would like to call the attention of the Board to page 29 of the agenda beginning with item 7 which covers reports of the various committees and commissions of this association. I particularly call your attention to item c, the Report of the Commission on Governmental Medical Services. This will open your eyes.

Dr. Petrich: Mr. Chairman, I move that this report be published in *The Journal* and attention called to *The Journal* article through the Newsletter.

The motion was seconded by Dr. Smith, put to vote and carried.

Reports of the other commissions were reviewed and attention was called to the request of the Commission on Voluntary Health Agencies appearing on page 38 of the agenda in which they want an additional $500 for the coming year.

Motion was made by Dr. Hillis and seconded by Dr. Petrich to grant the request for $500. The motion was further discussed by Dr. Santare, Mr. Bush and Dr. Schuster.

Chairman: Are we ready for the question? The question is on the motion by Dr. Hillis that we give them $500 over and above their budget. You have had discussion and now we are calling for the question. A request for a roll call vote was heard.

Roll Call Vote

Wilhelmus—nay; Joe Dukes—nay; Goodman—yea; Reid—absent; McIntosh—nay; Smith—nay; Gosman—yea; Schuster—yea; Ingram—nay; Sholty—nay; Santare—nay; Hillis—yea; Clark—nay; Gattman—yea; Scamahorn—yea; Petrich—yea; Thatcher—nay.

The right of Dr. Thatcher to cast the vote was questioned. It was pointed out that in the Constitution and Bylaws the assistant treasurer has a right to vote in the absence of the treasurer.

Chairman: The motion did not pass.

Resolution

Dr. Ingram: Our society felt that we are at the point where we are going to have to take some drastic action to maintain our right to practice medicine as free men. We have about decided that the only thing that will work is to balk and we wrote this resolution and adopted it without a dissenting vote.

"WHEREAS, the free enterprise, fee-for-service system of medical practice in the United States makes most efficient use of available medical personnel, encourages high quality medical care, and preserves the freedom of patient and doctor, and

WHEREAS, government intervention between practicing physicians and the patient historically removes responsibility from both parties and leads to decreasing quality of medical care, and

WHEREAS, the current proposals for Federal regimentation of medical care which are before the Congress (Senate Bill 3 and H.R. 7741) will result in total control of all patients and all doctors, with no free choice alternative, and

WHEREAS, the members of the Delaware-Blackford County Medical Society wish to continue to provide medical services in the most efficient manner, retaining freedom of choice for physician and patient alike, and retaining mutual respect and responsibility between patient and physician; and

WHEREAS, no plan of socialized medicine or other form of government-sponsored health care plan can function without cooperation and participation of the majority of physicians of the involved community,

NOW, THEREFORE, BE IT RESOLVED that the members of the Delaware-Blackford County Medical Society, in their effort to help preserve the American system of medicine in these counties and to thwart the promulgation of a national socialist medical system, do pledge ourselves to continue to care for our patients to the best of our ability, and do hereby notify the members of the Federal Congress and the general public that we will not participate in any Federally-sponsored plan of collectivized medical care now under consideration, including Senate Bill 3 or H.R. 7741, or any other such plan which may in the future be considered, if such plan includes provisions for: abandonment of fee-for-service system, forced abolition of individual patient-doctor with separate responsibility, national licensure of medical practitioners, forced relocation of physicians, involuntary servitude of physicians, abridgement of the right of privileged communication between the patient and doctor, institution of compulsory peer review requirements, establishment of any Federal regulations of medical practice except in the distribution of narcotics and dangerous drugs, and the removal of constitutional freedoms from any citizen."

Dr. Ingram, in continuing, stated that their society would like to submit this resolution to the Board for their consideration and possible recommendation from the Board when this comes to the House in the fall.

Chairman: Do I understand, then, you are presenting this to the House of Delegates? Therefore, we will take it under advisement at this time.

We have a letter from Fred Smith of Tell City, Chairman of the Impac Board, in which he transmits a proposal from that Board to the Board of Trustees for their consideration.

In 1968 the then Council of ISMA adopted a resolution calling for the Impac Board to be composed of one representative from each Congressional District, to be elected by the Council; two at large, to be elected by the Council; and the president and president-elect of ISMA, by virtue of their office. At the present time the two at-large member positions are open and the Impac Board respectfully requests of the trustees of ISMA that (1) the Chairman of the Board of Trustees of ISMA and the executive secretary be elected as its members-at-large of the Impac Board. (2) The Board also recommends that membership of the Impac Board be enlarged by one and this position be filled by the appointment of the Auxiliary of the ISMA, (3) We unanimously request the Board of Trustees of ISMA to review the membership of the Impac Board from the standpoint of attendance and participation.

Dr. Scamahorn: Mr. Chairman, I move that we act on each of the sections individually and I will additionally move that his first request be approved—namely, the election of the chairman of the Board of Trustees of ISMA and the executive secretary of this association as at-large members of the Impac Board.

The motion was seconded by Dr. Gattman, put to vote and carried.

Dr. Scamahorn: I move point 2 that we approve enlarging the Impac Board by one, the position be filled by appointment by the Auxiliary to the state association. The motion was seconded by Dr. Santare, put to vote and carried.

Chairman: On item 3, inasmuch as we do not have the information, I would suggest that Dr. Smith be invited to attend our next meeting to review the activities of the Board membership. It is possibly time that we work them over again.

Dr. Wilhelmus: I move that we have Dr. Smith send us a list of the members of the Impac Board and a record of their attendance. The motion was seconded by Dr. Stephen Smith, put to vote and carried.

Report of Dean Irwin, I.U. School of Medicine

Dr. Irwin: The Dean reported that the Indiana General Assembly had agreed to fund the establishment of seven regional campuses but appropriated only three and one-half million dollars rather than the requested seven million dollars. He pointed out that, even though the appropriation was reduced, they did plan to proceed with the increase of entering medical students by 100 during the next four-year period. He also reported that the legislature had seen fit to renew their support of the medical education program known as the Indiana Plan, originally funded in 1967.

Discussing applicants for medical school, he stated that 1300 applications have been received and they were planning to increase the entering class for September 1971 from 250 to 273. He pointed out, that, in spite of this increase, they would still be unable to accept many qualified students. He stated that of the present freshman class their academic performance was 3.3 on a 4 point scale.

As you are well aware, there has been some skepticism on the original Indiana Plan and of course there has been some concerning the new program of establishing the seven regional centers; however, I am very sure that, as a result of the survey, we will be fully accredited and we will be encouraged to continue the statewide system of medical education.

Dr. Shields: For the first time in 20 years I recommended two boys for entrance to medical school. One boy had a 3.5 up to his last semester of this year and the other one has a 3.6. However, neither was accepted. These boys are fundamental kids—shorthaired—one got his Ph.D. this year in anatomy. He has been offered a teaching job and one of the boys is marrying last year's 500 Queen. He comes from a long line of school teachers in his family. He is getting his Master's in anatomy at I.U. this year and both are determined to get into medical school but neither has been accepted. I question whether or not a physician should make a recommendation to an individual to enter medical school in the first place and essentially I am of the opinion that the recommendation of a physician does not carry any weight with the admissions committee. I am surprised to see that the average of the present class is 3.3 when these boys have higher averages and yet were not accepted.

Dr. Irwin: The Dean pointed out that they paid a lot of attention to recommendations of the profession but they have a 15-point criteria which they try to follow, pointing out that he did not know about the specific cases to which Dr. Shields referred, saying that they had not accepted some applicants as yet until they could determine just how many they could admit in the fall of '71. He also stated that many students, who were not being admitted to American medical schools are considering entering a school of medicine of another land.

We are going to spend some time in Europe in the near future studying this situation because in Europe, for example, it is reported some 1500 U.S.A. students are attending these schools and I am told we have about 25 from Indiana in this group. We have students in South American schools.

I am attempting to work out an agreement whereby if a student from Indiana passes the first two years of basic medical sciences and passes part I of the Board, he can then transfer to our medical school. Friday night we graduated 216 new MDs, our largest class.

The Dean was queried concerning out of state students and he pointed out that during the 70-71 year 600 applicants were from in-state and 700 from out of state. Last year they took eight out of state and this year only accepted seven.

Dr. Irwin was then asked a question concerning reducing the number of years in training — talk of three years.

Dr. Irwin: Unofficially and personally, I feel there should be a major effort in the area of reducing the length of training time. I think the traditional concept of four years of pre-medicine is archaic. I think there are students who can enter medical school after two years of undergraduate education. After three years' experience watching over our medical students, I am convinced that the Senior elective year is pretty much what a rotating internship was in the lives of many of us in this room. There are now about 22 schools that have or will soon have a three-year medical school curriculum and I feel we should have the same here in Indiana. I would also predict that the internship, as we have known it, will be discontinued and once a student gets his MD degree he will enter the specialty of medicine, whether it be family practice, surgery, etc.

The Dean also predicted that the residency period would be shortened. He further explained that Dr. Alan Fischer had been appointed head of the Family Practice Program which, he hopes, will be launched as a full time department with a statewide faculty and curriculum program at all levels.

He further explained that at the present time the University has 341 full time faculty members, about 35 of whom are scattered throughout the state; 108 are part-paid faculty who are based full time at the V.A. and General Hospital. He pointed out that there were 500 voluntary members of the faculty for a total of 1,033, but in spite of that impressive number we are, compared to the other medical schools, at a very low ratio of faculty to students. We also rank low in the amount of state support per student.

Report of Dr. Black, Chairman of the Blue Shield Board

Dr. Black: I would like to report to you that the income of Indiana Blue Shield now runs between sixty and sixty-five million dollars per year. Our reserves total about forty million. Income from reserves amount to $1,800,000 per year and, while membership growth has slowed somewhat, we are still providing a good health insurance plan to the people of Indiana.

Dr. Black further discussed the composition of the Blue Shield Board in relationship with the state insurance commissioner and the financial picture as to reserves and announced the fact that they had just completed an audit of the activities of the Plan for the last three years.

Reports of AMA Delegates

Dr. Corcoran: I was assigned pages 821 through 829 of the Handbook, which is the financial statement. As far as I am concerned, the financial statement is a dismal one and while they can be misleading, from my arithmetic, the assets of the AMA have been depleted in a year on paper by $1,167,000. If you look at what happened to other securities, the total decline amounted to $2,399,000. They raised another $1,100,000, but that is a bit misleading because corporate securities show $800,000 more but that is money put into it. The net is $100,000 loss in market value. In reviewing their financial statement, I would not buy stock in this company myself.

Dr. Corcoran also covered Report B of the Board of Trustees having to do with the "Primary Physician's Assistant." Also Report C dealing with the "Use of Term Physician's Associate." Report D concerning "Improved Liaison with House Staff".

Dr. Harshman: Dr. Harshman reported on pages 859-873 of the Handbook which involved Report A of the Council on Medical Education dealing with "Revision of Essentials of Approved Residencies"; Report B of the Council on Medical Education dealing with SAMA Extramural Programs; Report C of the Council on Medical Education dealing with the subject of "Teaching of Medical Students."

The report was accepted by the Board for information.

Dr. Rifner: The report of Dr. Rifner covered pages 874 through 880 of the Handbook. The report deals with Report A of the Council on Medical Service dealing with "Mediation of Physician-Hospital Disputes." Report B of the Council on Medical Service dealing with "Selection and Role of the Medical Staff Member on the Hospital Governing Board." Also covered was report C of the Council on Medical Service dealing with "Peer Review-Glossary of Terms."

The report was ordered adopted for information.

Dr. Green: The report of Dr. Green covered pages 897 thruogh 901, containing a report of the Specialty Section Ad Hoc Committee dealing with a change in the Constitution and Bylaws; also Resolutions 1, 2, and 3 dealing with scheduling of meetings at annual convention; Standard Medical Nomenclature; and Malpractice Claim Problems.

Dr. Farquhar: The report of Dr. Farquhar covered pages 830-839 of the Handbook dealing with Report F of the Board of Trustees concerning Emergency Medical Services; Report G of the Board of Trustees dealing with the AMA symbol of Emergency Medical Identification. Report H of the Board dealing with Representation of the American College of Emergency Physicians, Report I of the Board dealing with Teenage Pregnancy; Report J of the Board dealing with Centralized Community and Regionalized Perinatal Intensive Care; Report K of the Board dealing with National Health Insurance and Truth Force.

Dr. Don E. Wood: The report of Dr. Wood covered pages 850 through 858 of the Handbook. Dr. Wood outlined the provisions of Report T of the Board of Trustees dealing with nominations for Council on Medical Service: the report of the Executive Vice President; report of the Constitution and Bylaws Council dealing with change in membership classification.

Dr. Shields: Dr. Shields report covered pages 840-849 of the Handbook.

Before I make my report, I would like to announce that I was elected trustee for the Fourth District and I would like to introduce Dr. Jackson, who was elected the alternate-trustee to serve out my unexpired term. I offered to take the trusteeship for one year and at the end of that year he would be ready to step in as trustee. We are hoping that we can find another young man from somewhere in the Columbus area who can step in as alternate when Dr. Jackson is advanced to the trusteeship.

My report covers Report L of the Board of Trustees dealing with the "Mirex Fire Ant Program"; Report M of the Board dealing with the "Resume of House of Delegates Handbook"; Report N of the Board setting forth the Scope, Objectives and Functions of the Occupational Health Program; Report O of the Board dealing with "Physician Manpower and Medical Education" Report P of the Board on the subject of "Professional Liability"; Report Q on "Computer Systems in Medicine" and Report R setting forth the Nominations for the Council on Constitution and Bylaws; and Report S dealing with Nominations for Council on Medical Education.

Dr. Tyrrell: The report of Dr. Tyrrell covered Resolutions 4-11 dealing with the Increase in Private Practitioners' Participation in Narcotic Addiction Control Programs; FDA Practices of Removing Drugs from the Market; Restrictions on the Use of Stimulant Drugs; Advertisements in the Mass Media on Mood-Changing and Analgesic Drugs; Support of Continued Government Funding for Basic and Applied Research; Amendment of the Social Security Act to Change Qualifying Dates; Use of Safety and Impact Resistant Materials in Eyeglasses; and Extension of the Appeal Period to the Judicial Council of the AMA.

Dr. Senseny: The report of Dr. Senseny covered pages 881-896 of the Handbook. Dr. Senseny reported on Report D of the Council on Medical Service dealing with "Health Maintenance Organization Programs" which evoked quite a bit of discussion on the part of those present at the meeting.

Dr. Petrich further discussed the report, along with Dr. Owsley, Dr. Santare, Dr. Hoyt, Dr. Ingram and Dr. Clark.

A motion was made by Dr. Sholty that we, as a Board, authorize Dr. Petrich to write a resolution stating our objections to HMO and then he could do it as he sees fit.

The motion was further discussed, it being pointed out that some six or seven of the delegates and officers would be in Atlantic City on Saturday prior to the date line for introducing resolutions. Following the discussion, Dr. Sholty withdrew his previous motion.

Dr. Sholty: I move that we authorize the delegation to attempt to amend the report before it goes to the Reference Committee or to present a resolution on the floor of the House, whichever they see fit. The motion was seconded by Dr. Shields, put to vote and carried.

Dr. Senseny then discussed the campaign on planning to elect Dr. Don E. Wood to the Board of Trustees. He continued by reading a resolution which he proposed for submission to the AMA House of Delegates. On motion duly made and seconded, the resolution was approved for submission to the AMA House of Delegates.

Chairman: If there is no further business, I will announce that the delegates' breakfast in Atlantic City will be held promptly at 7 o'clock on Monday evening in the Terrace Cocktail Lounge of the Chalfonte-Haddon Hall Hotel.

Next Meeting

We therefore stand adjourned to meet again at 8:30 a.m. Sunday, August 22, in the Headquarters Building.

EXECUTIVE COMMITTEE

August 21, 1971

The Executive Committee convened in the Headquarters office at 4:00 p.m., Saturday, August 21, with Dr. Donald M. Kerr, Chairman presiding. Roll call showed the following present: Donald M. Kerr, M.D., Wilbert McIntosh, M.D., Malcolm O. Scamahorn, M.D., Peter R. Petrich, M.D., Joe Dukes, M.D., Lester H. Hoyt, M.D., Hugh K. Thatcher, M.D., Frank B. Ramsey, M.D., and Jas. A. Waggener. Paul Inlow, M.D., of Shelbyville, a member of the Board was also in attendance.

MINUTES OF THE MEETING held June 12, 1971, were approved on motion of Dr. Hoyt and Dr. Dukes.

MEMBERSHIP REPORT was reviewed and taken for information.

Membership report as of July 31, 1971:

Number of members as of December 31, 1970	4,505
1971 members as of July 31, 1971:	
Full dues paying members	3,948
Residents and interns	80
Senior	373
Board Remitted	54
Honorary	3
Military	34
Total 1971 members as of July 31, 1971	4,492
Total 1970 members as of July 31, 1970	4,456

Number of AMA members as of December 31, 1970	4,337
Number of AMA members as of July 31, 1971	4,237
Full dues paying	3,695
Exempt, but active	542
	4,237
Number who paid state dues but not AMA dues as of July 31, 1971	252
Number who paid state dues but not AMA dues as of December 31, 1970	168

Headquarters Office

CLEANING SERVICE—A new contract for the cleaning service of the building was approved on motion of Dr. Petrich and Dr. McIntosh.

CHAMPUS AUDIT AND VISITATION REPORT—The secretary read a report on the Champus audit and visitation report which was taken as a matter of information.

REQUEST OF RMP—The request of the Indiana Regional Medical Program for use of the building for a meeting on October 1 was approved by consent and the secretary is instructed that this group may use the building when requested, if not in conflict with other association meetings, without referring this to the Executive Committee.

TREASURER'S REPORT—The treasurer gave the report on the 10-month analysis of receipts and expenditures and the investment portfolio. The report was approved on motion of Dr. Hoyt and Dr. Dukes.

Organization Matters

A letter from a Fort Wayne physician concerning payment of his employees was read and he is to be advised to consult his local CPA or attorney for the answers to these questions.

REQUEST FOR MAILING LIST—A request for the mailing list by the I.U. Dept. of Urology was approved on motion of Dr. Hoyt and Dr. Dukes.

The request for the use of the mailing list by the Veterans Administration was approved on motion of Dr. Dukes and taken by consent.

LETTER FROM MASONIC HOME—A letter from the Chief of Staff of the Masonic Home Hospital in Franklin was read and, by consent, the letter is to be referred to the Board of Trustees.

LETTER FROM IRMP—A letter from the Regional Cancer Coordinator of the Indiana Regional Medical Program was reviewed and, by consent, was referred to the Board of Trustees.

ADVERTISING REQUEST AAMA—A request from the American Association of Medical Assistants, Inc., for the association to purchase space in their Convention Issue was reviewed and, by consent, it was agreed to take a line greeting at the price of $25.00.

LETTER FROM ROBERT B. FORNEY, Ph.D.—A letter from Robert B. Forney, Ph.D., thanking the association for recommending him for a position on one of the AMA Councils and informing them he would be unable to accept was read for the information of the committee.

LETTER FROM DEPT. OF PUBLIC WELFARE—A letter from the Department of Public Welfare concerning the establishment of a Peer Review mechanism for the Medicaid Program was reviewed and, on motion of Dr. Scamahorn and taken by consent, this is to be referred to the Commission on Governmental Medical Services.

CHIROPRACTIC RELATIVE VALUE SCHEDULE—A Relative Value Schedule for chiropractic services under the Medicaid Programs was reviewed and on motion of Dr. Scamahorn and taken by consent, the suggestion is to be made that this should be referred to the Welfare Medical Advisory Board.

CHANGE IN PRECEPTOR PROGRAM—Correspondence concerning the development of the Department of Family Practice Preceptorship Program was reviewed and by consent referred to the Commission on Medical Education and Licensure.

RMP July 7 Meeting—A report of the RMP meeting of July 7, 1971 setting forth the goals and objectives of the Indiana Regional Medical Program is to be duplicated and forwarded to the members of the Executive Committee.

INDIANA ASSN. OF PUBLIC HEALTH PHYSICIANS LETTER—A letter from the Indiana Association of Public Health Physicians announcing a proposed resolution was taken as a matter of information.

AMA LETTER COMMITTEE ON HEALTH CARE OF THE POOR—A letter from the AMA concerning the establishment of a Committee on Health Care of the Poor was reviewed and by consent this is to be assigned to the Commission on Special Activities for implementation.

LETTER FROM OCHAMPUS—A letter from OCHAMPUS inquiring if the association would be willing to take on the additional responsibility under the program of evaluating Handicapped and Psychiatric Facilities was reviewed and by consent the secretary was authorized to inform OCHAMPUS we would accept this additional responsibility.

LETTER FROM DR. OFFUTT—A letter from Dr. Offutt concerning the vacancy created by the death of Dr. G. O. Larson on the Indiana Advisory Comprehensive Health Planning Council and the Advisory Hospital and Health Facilities Planning Council was read and on motion of Dr. Dukes and Dr. Petrich the name of Malcolm O. Scamahorn is to be transmitted as a replacement for Dr. Larson.

REQUEST OF IPHA FOR DONATION—A request for a donation to the Indiana Public Health Association was turned down by consent.

LETTER FROM DEPARTMENT OF HEW—A letter from the Department of HEW concerning P. L. 91-623 was reviewed and taken as a matter of information.

LETTER FROM DR. ROSS EGGER—A letter from Dr. Egger concerning a 1971 ISMA Student-Faculty Retreat was reviewed and on motion of Dr. Scamahorn and Dr. Petrich, the yearly repeat of this Retreat is to be transmitted to the Commission on Medical Education and Licensure with the request that they should make a report to the House of Delegates annually concerning this function.

LETTER FROM THE INDIANA HIGHER EDUCATION TELECOMMUNICATION SYSTEM—A letter from the Indiana Higher Education Telecommunication System requesting the Indiana State Medical Association to name a representative to their Advisory Council was read and by consent the name of Dr. Louis Robbins is to be submitted as the association nominee.

MINUTES OF MEETING OF MEDICAL REGISTRATION BOARD—The minutes of the meeting of the Board of Medical Registration and Examination held August 3rd was reviewed and by consent it was recommended that the president and the executive secretary obtain an appointment with the Governor to discuss some of the actions of the Board.

LETTER FROM AMA RE MEDICAID FRAUD—A letter from the AMA regarding fraud under the Medicaid program and dealing with certification and verification of services rendered was reviewed and taken as a matter of information.

COPY OF HOSPITAL ACCREDITATION QUESTIONNAIRE—A copy of a letter from the AMA concerning the Hospital Survey Questionnaire, Part I, Joint Commission on Accreditation of Hospitals was reviewed and taken as a matter of information.

COPY OF NEW YORK LAW—A copy of the law recently passed in New York permitting cities and towns to raise by taxation funds for the employment of physicians for the inhabitants thereof was reviewed for the information of the committee.

Annual Convention

LETTER FROM DR. WESLEY W. HALL—A letter from Dr. Wesley W. Hall, President of the AMA, accepting the president's invitation to address the ISMA annual convention was reviewed for the information of the committee.

LETTER FROM DR. S. O. WAIFE—A letter from Dr. S. O. Waife, chairman of the Commission on Convention Arrangements, concerning the plans for the program on Tuesday evening and Thursday morning was reviewed for the information of the committee.

REQUEST FOR GOLF PRIZE—A letter from the Chairman of the Golf Committee of the Convention requesting an appropriation of $150 for golf prizes was reviewed and the request approved on motion of Dr. Scamahorn and Dr. Petrich.

LETTER REGARDING SPEAKERS' COST—A letter regarding the cost of speakers for the annual meeting from the Chairman of the Convention Arrangements Commission was reviewed for the information of the committee.

LETTER FROM DR. WAIFE—A letter from Dr. Waife transmitting the request of the Section on General Practice to place a surcharge on their luncheon tickets so they could pay a larger honorarium to some of the speakers was reviewed and Dr. Waife is to be advised that the Board of Trustees has established a number of dollars to be spent for this purpose and therefore a surcharge would not be acceptable.

The Journal

A request for space in the Journal from Weight Watchers was reviewed and the copy, as submitted, was declared unacceptable and Dr. Ramsey was directed to discuss with them appropriate copy and, if they would agree to the type copy suggested, say that the space would be sold to them.

Legislation

The President-elect brought up a discussion of the Medical Practice Act, the Medical Disciplinary Act and the Sick Doctor Statute and, by consent, the President-elect was requested to present this and his ideas to the Board of Trustees.

New Business

ANNOUNCEMENT FROM PA. STATE MEDICAL ASSN.—An announcement from the Pennsylvania State Medical Association that they would propose Dr. Russell B. Roth as a candidate for President-elect in 1972 was taken as a matter of information.

ANNOUNCEMENT FROM TENN. MEDICAL ASSOCIATION—A letter from the Tennessee Medical Association announcing that they propose to run Dr. Tom E. Nesbitt of Nashville for the position of Vice-speaker of the AMA was taken as a matter of information.

FEE SPLITTING LAW—The President-elect reviewed a letter from the Institute of Medicine of Chicago regarding a law which was passed prohibiting fee splitting for the information of the committee.

Future Meetings

A letter from the AMA inviting representatives to be sent to a meeting of the Committee on Governmental Medical Services for a discussion of Champus and Medicaid to be held in Chicago on Friday, Aug. 27, was reviewed and, on motion of Dr. Petrich and Dr. Dukes, the executive secretary is to represent the association at this meeting.

An invitation for representatives to be sent to a Regional Meeting of the Health Insurance Council to be held in Chicago September 9-10 was read and it was decided no representative would be sent.

An invitation to send representation to a meeting of the Congress of County Medical Societies to be held in Anaheim, Calif., was read and it was determined no representative would be sent.

Attention was called to the Joint Committee on Practice meeting in Indianapolis on Wed., Sept. 22, and representatives of the association are to be Dr. Scamahorn, Dr. Petrich and Mr. Waggener.

Another announcement concerning the 17th Annual Conference of State Mental Health representatives to be held in Chicago on September 24-25 was read and the committee had previously decided Dr. Betty Dukes would represent the association at this meeting.

An invitation from the Blue Shield Plan for the Executive Secretary to attend the Program Conference in Washington, D.C. October 8-9 was reviewed and, by consent, the secretary is authorized to attend, if possible.

Announcement of the U.S. Chamber of Commerce Aircade meeting in Indianapolis on October 27 and the Public Affairs Conference of the Indianapolis Chamber of Commerce to be held in Indianapolis on November 9-10 was called to the attention of the committee for their information.

Next Meeting

There being no further business, the committee adjourned to meet again Mon., Oct. 11, at 9:00 a.m. in the Hilton Hotel.

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DIRECTLY ON quiet Cocoa Beach, nearest beach to Disney World and Space Center, 3-bedroom beach house, furnished; sleeps 10; $200 per week. For info write Cypress Lodge, 105 LaRiviere Road, Cocoa Beach, Fla. 32931.

PRACTICE FOR SALE: Well established General Practice; Southern Indiana city; population 150,000; Gross $75,000; equipped with X-ray and laboratory facilities; moving to Florida; will introduce. Write Box 367, The Journal, ISMA, 3935 N. Meridian St., Indianapolis 46208.

EASTERN ILLINOIS progressive community 42,600 population; Universities of Illinois, Indiana and Purdue nearby; good schools, including Junior College adjacent to hospital; new, well equipped General Medical and Surgical Hospital; interested in all specialities as well as GP; away from busy metropolitan traffic; 120 miles south of Chicago, 85 miles west of Indianapolis via I-74; beautiful 9-hole championship golf course on grounds; an equal opportunity employer; salary $20,815 through $31,523 based on training and experience. Licensure in one state required for appointment. Write or call Chief of Staff, Veterans Administration Hospital Danville, Ill. 61832. Telephone: Area Code 217, 442-8000, ext. 353.

LUCRATIVE practice opportunities for General and/or Family Practice, OB-Gyn, and General Surgeon. JCAH accredited county general hospital available in town of 10,000 with service area of over 20,000 population near new plant of Indiana based ethical drug manufacturer. Contact: Administrator, Vermillion County Hospital, Clinton, Indiana 47842. Tel. (812) 832-2451.

WANTED — well trained internist or general practitioner who is interested in improving and expanding the physical exam department of an industrial clinic in Indianapolis. The physical exams include routine pre-employment, executive and special examinations. Reply Box 371.

ORTHOPAEDIC SURGEON WANTED

TO JOIN three man orthopaedic surgeons clinic in progressive, well industralized, attractive, midwest city.
Call collect or write for details to: Orthopaedic Clinic 402 South Berkley Road, Kokomo, Indiana 46901. Telephone: (317) 457-4401.

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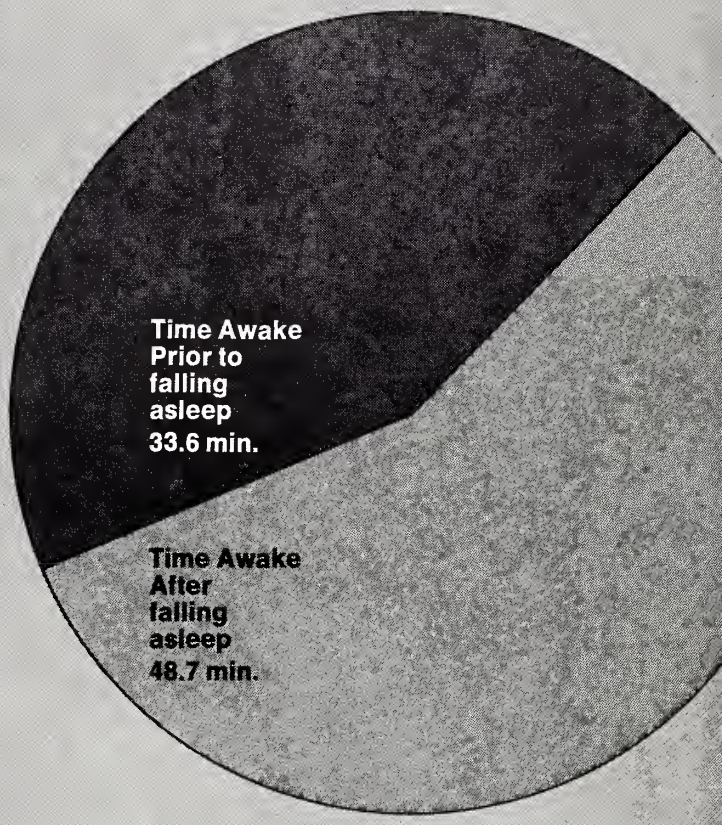
These studies utilized identical protocols and included eight insomniac patients. Sleep laboratory measurements in a limited number of patients are derived from all-night electro-encephalographic, electro-oculographic and electromyographic tracings. Unlike traditional methods of evaluation, they are quantitative, reproducible and projectable to large numbers of subjects.

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References: 1. Frost, J. D., Jr.: "A System for Automatically Analyzing Sleep," Scientific Exhibit presented at Clinical Convention, A.M.A., Boston, Nov. 29-Dec. 2, 1970, and Aerospace M.A., Houston, April 26-29, 1971.
2. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J.

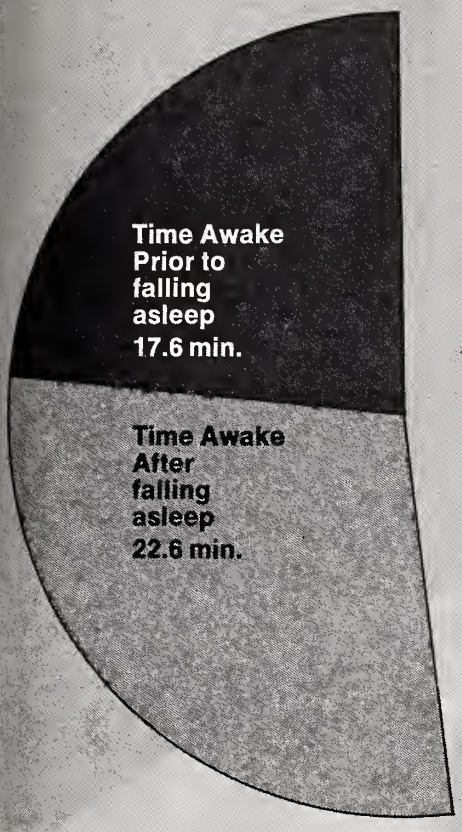
Before
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(flurazepam HCl)



Measurements of sleep in the sleep laboratory are obtained with electroencephalographic, electro-oculographic and electromyographic recordings.

ınd slept through the night

On
Dalmane
(flurazepam HCl)



age sleep laboratory measurements in cited studies

meter	Before Dalmane	On Dalmane
required to fall asleep	33.6 min.	17.6 min.
e time after onset of sleep	48.7 min.	22.6 min.
ber of wakeful periods after set of sleep	12.2	8.4
sleep time	420.0 min.	447.5 min.
sleep percent	88.6	94.5

inical effectiveness as
oven in the sleep laboratory

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Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

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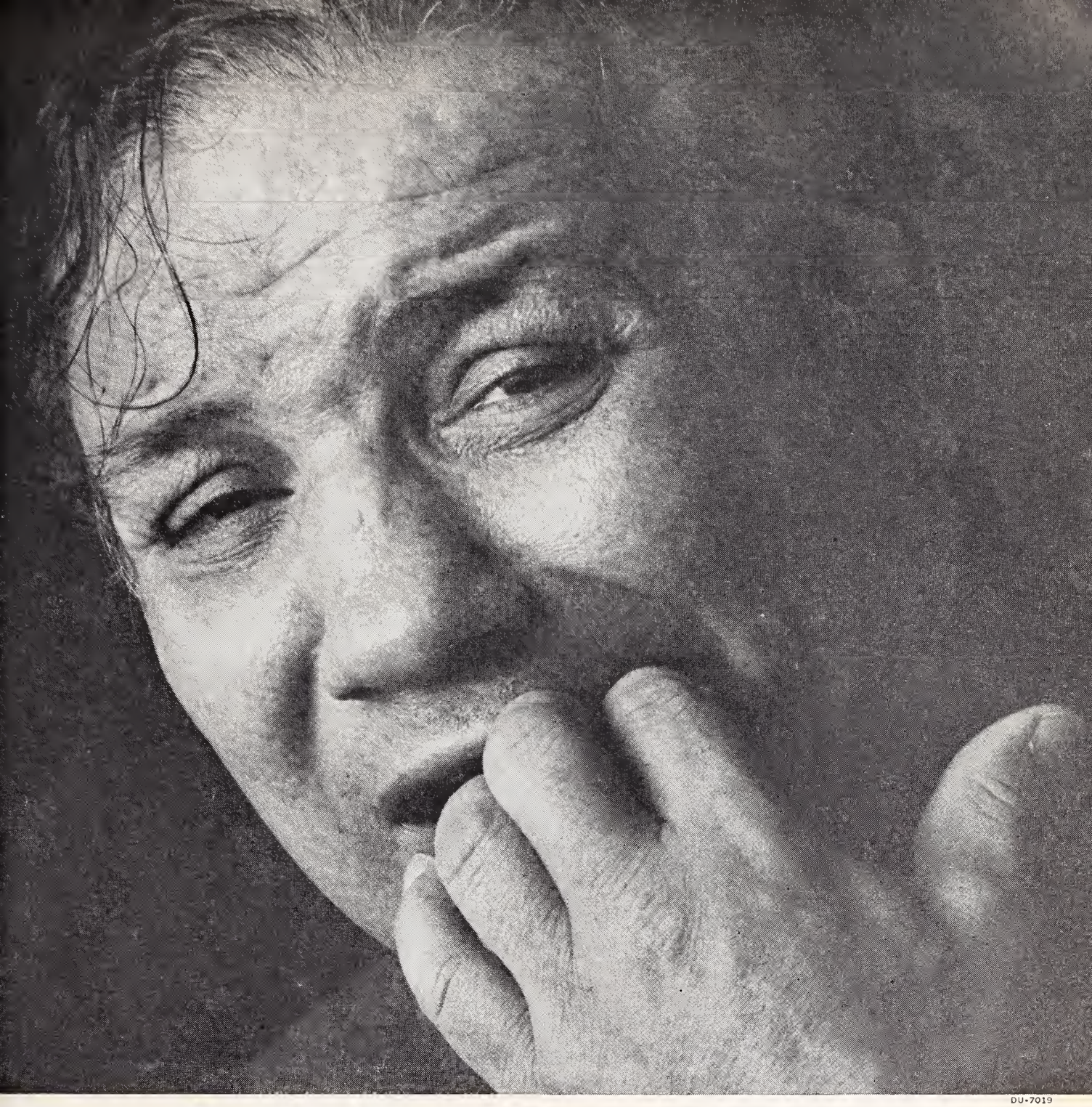
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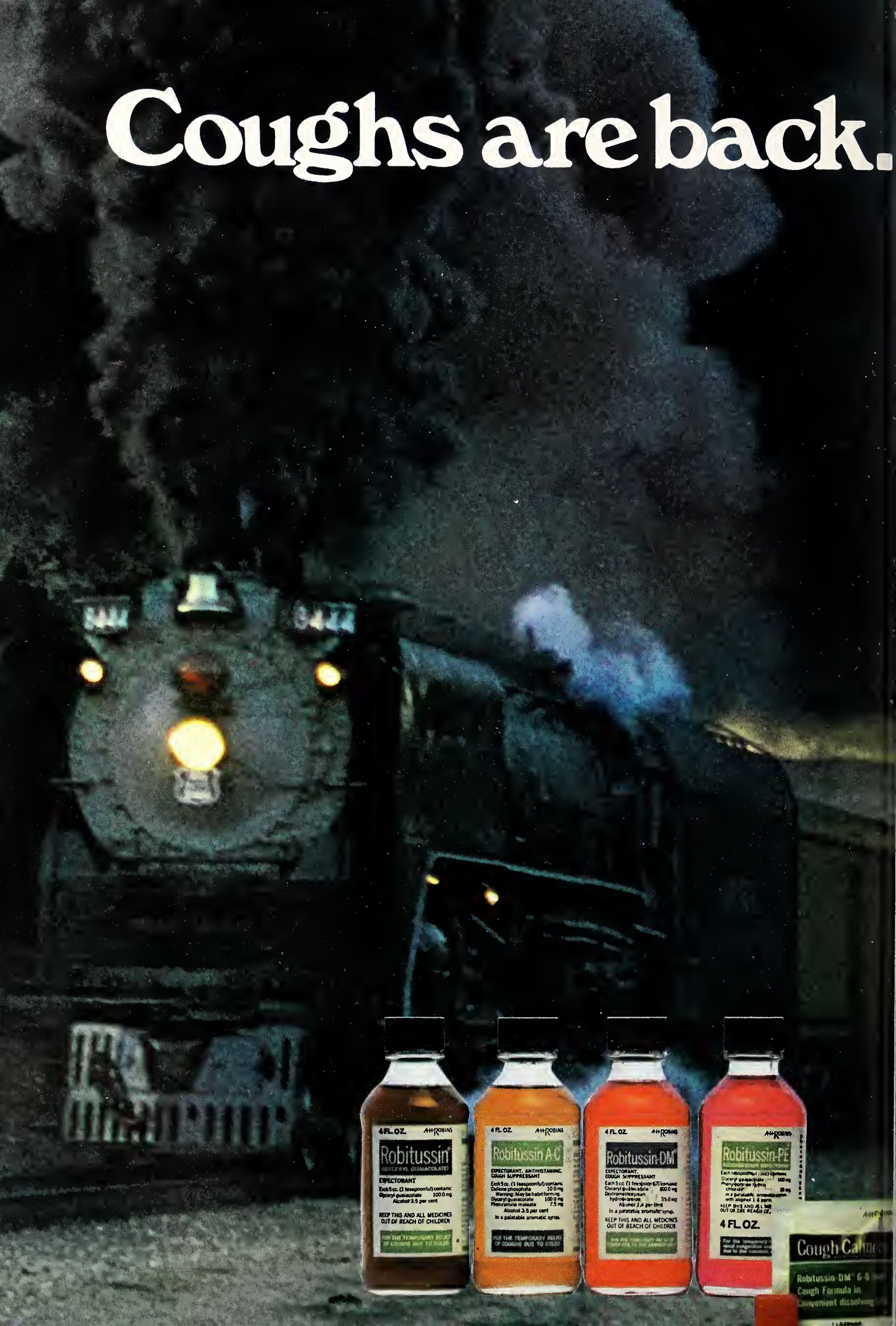
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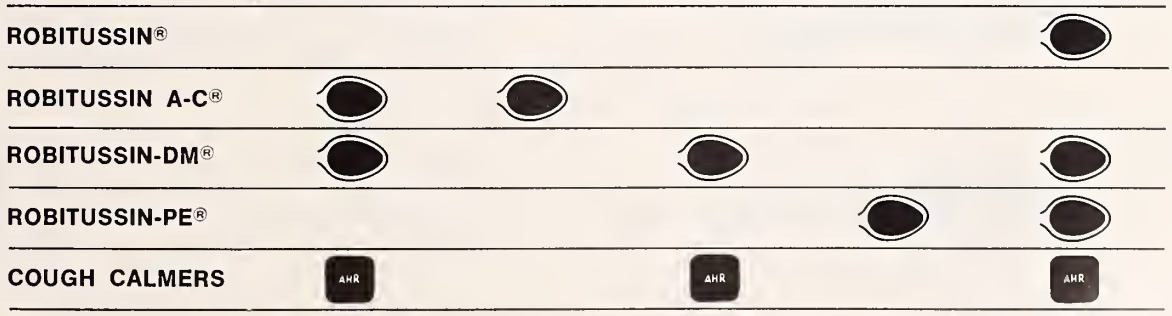
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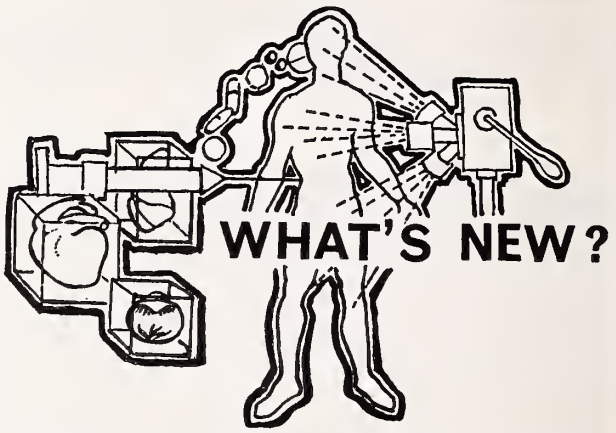
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Cambridge Instrument announces a new electrocardiograph which meets completely the safety and performance standards set by the American Heart Association. The name is VS 4. It also satisfies the safety and construction requirements of the Underwriters' Laboratories and the Canadian Standards Association. It achieves unprecedented levels of patient and operator safety.

* * *

"Emergency Care and Transportation of the Sick and Injured"—a 59-chapter book with over 200 illustrations—has been published by the American Academy of Orthopaedic Surgeons. It is valuable for those conducting education of emergency medical technicians, ambulance attendants, firemen, policemen and others. The price is $4.95 prepaid. Write the Academy at 430 N. Michigan Ave., Chicago 60611.

* * *

Doubleday just published *Schweitzer: A Biography* written by George Marshall and David Poling. Marshall was an intimate friend of Dr. Schweitzer's and a great theologian. Poling is president of *The Christian Herald*. The book is said to probe into and to portray all the many facets of Schweitzer's life; it is the first biography since his death in 1965; 360 pages, $7.95.

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Posey has a soft padded bar which comes with the proper hardware to enable its installation across the lap of a patient in a wheelchair. The bar is adjustable both vertically and horizontally to fit comfortably and maintain the patient in a stable position without tendency to scoot forward.

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COMPOSITION: Each tablet or 10 cc. (2 teaspoonsful) of liquid contains:

Chlorpheniramine Maleate ..... 4 mg.
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In a special pellet form providing both prompt and sustained effect.

INDICATIONS: For relief of upper respiratory and bronchial congestion associated with: the common cold, hay fever and allergies, sinusitis, influenza, and vasomotor and allergic rhinitis.

CONTRAINDICATIONS: Sensitivity to antihistamines or sympathomimetic agents. Severe hypertension or severe cardiac disease.

PRECAUTIONS: Use with caution in patients with hyperthyroidism. Patients susceptible to the soporific effects of chlorpheniramine should be warned against driving or operating machinery should drowsiness occur.

CAUTION: Federal law prohibits dispensing without prescription.

SUPPLIED: Tablets: Bottles of 100; Liquid: Pints and gallons; Timesules: Bottles of 50, 250, and 1000.

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40-50 pounds:		¾-1 tsp. q. 3-4 h.	
30-40 pounds:		½-¾ tsp. q. 3-4 h.	
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MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

PRESIDENT NIXON'S sweeping economic proposals have pushed aside chances for Congressional hearings on national health insurance until after the first of the year. Four of the Nixon economic proposals require legislative action and this will keep the House Ways and Means Committee busy at least through September and probably longer. Coupled with Congress' announced intention of adjourning in late October or early November, this could delay congressional action on national health insurance until late 1972, or possibly until the convening of a new congress in 1973.

WHILE THE HOUSE Ways and Means Committee considers the Nixon economic proposals, the Senate Finance Committee will consider the Social Security Amendments (H.R. 1) already passed by the House. Chances are that the Senate will delete the Administration's welfare proposals (Family Assistance Plan) from H.R. 1 and add Senator Wallace F. Bennett's (R.-Utah) Professional Standards Review Organization proposal of last year. Enactment of this legislation prior to adjournment is considered likely.

ALSO considered likely to be enacted prior to adjournment are the health manpower bills presently in conference. This legislation would authorize an estimated $3.3 billion in aid to health profession students and their schools in the next three years and provide facilities and programs to close the manpower shortages in the health professions within seven years.

HEW COMMISSION TO STUDY MALPRACTICE PROBLEMS

A HEALTH, Education and Welfare Commission has been formed to study the entire range of medical malpractice problems. The commission will conduct a series of public hearings on the fundamental causes behind the rising number of malpractice claims and their effects on the health care system, the legal system, the insurance industry and the general public.

IN ANNOUNCING the commission's membership, HEW Secretary Elliott Richardson said, "I feel confident this oustanding group will make a

major contribution toward solving one of the nation's most vexing health care problems."

HEADED BY Attorney Wendell Freeland of Pittsburg, Pennsylvania, the newly created Commission on Medical Malpractice will represent health care providers and institutions, the legal profession, the insurance industry and the general public. Acting as additional consultants to the commission will be advisory panels composed of experts in the disciplines directly concerned.

THE COMMISSION will compile statistical data and other relevant information in a series of studies conducted by HEW primarily through contracts with non-government research organizations and universities.

ELI P. BERNZWEIG, HEW's specialist in the medical malpractice area, has been named executive director of the commission staff. Loren F. Taylor, M.D., professor of anesthesiology at the University of Kansas Medical Center, has been named Deputy Executive Director.

THE COMMISSION will make a final report with recommendations to the HEW Secretary.

CHARLES HOFFMAN, M.D., president-elect of the American Medical Association and member of the AMA Board of Trustees, is one of the commission members. Others are:
Vincent H. Cohen, Hogan and Hartson, Washington, D.C.; Bernard J. Conway, Assistant Executive Director, American Dental Association; Mrs. Helen Creighton, R.N., LL.D., Prof. of Nursing, University of Wisc.—Milwaukee; William J. Curran, LL.D., S.M. Hygiene, Prof. of Legal Medicine, Harvard Medical School; Wendell Freeland, Pittsburg; Howard Hassard, Hassard, Bonnington, Rogers & Huber, San Francisco; Paul B. Jarrett, M.D., Phoenix, Ariz.; Henry T. Kramer, President, N. American Reinsurance Corp; John E. Linster, Senior Vice President, Employers Insurance of Wausau, Wausau, Wisc.; James E.Ludlam, Musick, Peeler & Garrett, Los Angeles; Richard M. Markus, Sindell, Sindell, Bourne, Markus, Stern and Spero, Cleveland; Edward H. Morgan, Asst. Secy., Casualty Underwriting—Dept. C11, Aetna Casualty and Surety Company, Hartford, Conn.; George W. Northup, D.O., Editor, American Osteopathic Ass'n Journal, Livingston, N.J.; Miss Audra Marie Pambrun, R.N., Director, Community Health Aides, Blackfee Community Action Program, Browning, Mont.; Mrs. Esther G. Schiff, Legal Counsel, Mt. Sinai Hospital of Greater Miami, Miami Beach, Fla.; Monroe E. Trout, M.D., J.D., New Canaan, Conn.; and Carl E. Wasmuth, M.D., J.D., Chairman, Board of Governors, The Cleveland Clinic Foundation, Cleveland, Ohio.

AMA PRESIDENT HALL PRAISES NATION'S PRESS

THE PRESIDENT of the American Medical Association, Wesley W. Hall, M.D., recently praised the nation's press for a "growing sophistication" in dealing with health care issues.

SPEAKING before an audience of newsmen, federal officials, and health organization representatives at the National Press Club, Washington, D.C., Dr. Hall said "This is a most healthy development." Many news stories now analyze the issues raised and challenge and dispute assumptions rather than follow a

"hackneyed theme,"he said.

"IF THE PEOPLE are fully informed,we doctors of America will put our trust in their ability to make the right decisions . . . I find it encouraging that the press is approaching this subject with maturity, with skepticism and, most of all, with an open mind."

NOTING that the AMA's Medicredit bill has attracted over 150 sponsors Dr. Hall said this doesn't mean that Medicredit is going to be enacted but does "mean that a substantial number of congressmen and senators agree with the principles that we use in drawing up a program and offering it to Congress."

DR. HALL SAID Medicredit makes available to everyone under 65 a private program of complete medical and health care protection, covering both the ordinary and the catastrophic expenses of illness or accident.

"THE PROTECTION can be a health insurance policy, membership in a prepayment plan or membership in a prepaid group practice. Each patient is left free to choose the kind of care he wants, and each physician is left free to practice as he wishes—alone or with other physicians."

THE MOST IMPORTANT thing about Medicredit, said the AMA official, is that it maintains freedom for the patient as well as for the physicians.

"WE BELIEVE that there is a lot of good in the present system. Two million Americans a day see their doctor, and although this probably is not all who should see a doctor, there is no reason to throw out the system that has this capacity. Rather we should build build on it."

CONGRESSMAN CALLS FOR SEPARATE HEALTH DEPARTMENT

THE AMA'S often expressed desire to see the establishment of a separate Department of Health with cabinet status has again been brought to the public's attention with the announcement of Congressman Paul G. Rogers (D.-Fla.), chairman of the House's subcommittee on health, that he will shortly introduce such a measure.

THE ISSUE SEEMS to turn on the intertwined questions of which committees in Congress have the job of enacting and overseeing a national program and how the federal government will administer it.

DURING the past 10 years or so health has mushroomed as an economic force in American life, and as a function of government. Neither congress nor the executive branch has been able to keep pace organizationally with the changes.

CONGRESSMAN ROGERS' call for a separate health department is considered to be part and parcel of this behind-the-scenes jockeying by the Congress for more authority in health care matters. If a Department of Health were established, Rogers' subcommittee could claim authority over all of the activities of the new department and drive to establish a permanent full committee on health.

HOWEVER, Rogers' proposal runs head-on against current thinking in the administration where policy has jelled in support of the current tri-function HEW apparatus. The trend of ad-

ministration thought is that fewer departments make for more efficiency and coordination, less bureaucracy.

ACTUARIAL STUDY RELEASED

A COMPREHENSIVE actuarial study of all the major proposals for national health insurance arrangements prepared by HEW has been released for the information of congressional committees studying the issue.

THE ACTUARIAL REPORT'S prediction of gross underfinancing in the Kennedy proposal for federal assumption of the bulk of health care costs was the most noteworthy item in the 83-page report. The work was reviewed by outside experts to check on its fairness and soundness.

THE MAJOR plans before Congress would compare in terms of additional costs to the government as follows:

Administration—$2.6 billion
Kennedy—$59.4 billion
Medicredit (backed by the AMA)—$6.3 billion
Burleson (the health insurance industry plan)—$7.3 billion
Javits (Medicare for all)—$41.6 billion
Hall-Long (catastrophic only)—$3.2 billion, $3.1 billion
Pell-Mondale (mandated employer plans, health care corporations)—$4.9 billion

FOR THE MOST PART, these costs represent "transferred" spending from the private sector to the federal sector. In the case of Medicredit, financed largely by tax credits for purchase of comprehensive private insurance, most of the "cost" represents a revenue loss rather than an additional expense.

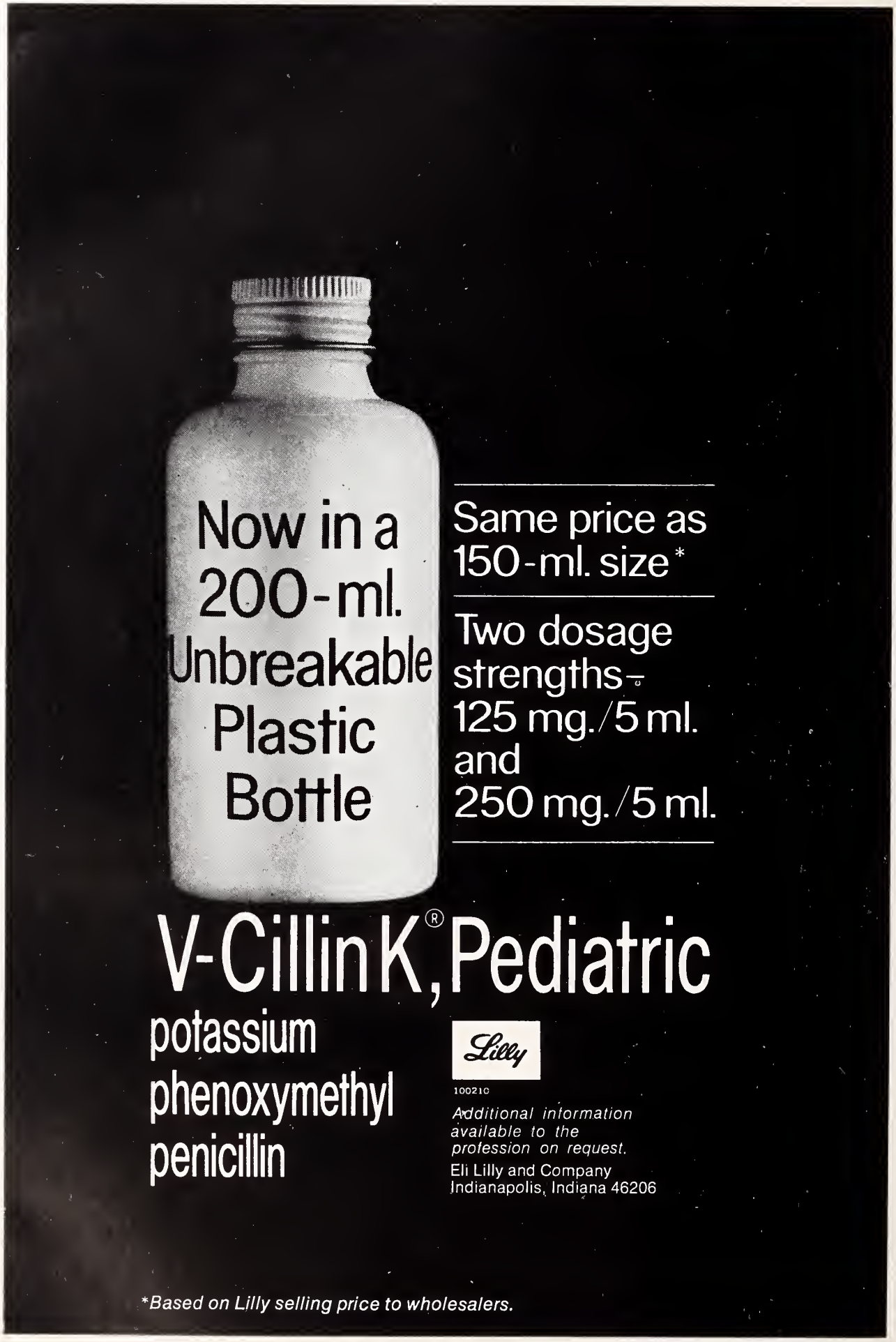
THE HEW REPORT said overall federal spending under the Kennedy bill, including existing programs it would take over, would total $81.6 billion in the fiscal year 1974, but that the proposed financing would raise only $57 billion. Thus, it would be under-financed by 43%, or $24.6 billion.

NATIONAL HEALTH expenditures of all kinds will rise to $105.4 billion in fiscal 1974, an average increase of 12% a year, if none of the major proposals is enacted. Operation of the Kennedy program in fiscal 1974 would result in total U.S. health spending (government and private) of $113.8 billion; the administration bill, $107.2 billion; the insurance industry bill, $110 billion; and Medicredit, $109.5 billion. ◄

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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Volume 64 — October 1971 — Number 10

A History of the Beginning of Medicine in Indiana

THE HONORABLE CURTIS G. SHAKE, LL.B.
Vincennes

FOR the first 75 years of its existence, Vincennes, established 1732, was without a resident physician. All the medical service that was available to its citizens during that long and trying period was supplied by itinerant herb doctors, Indian medicine men and, occasionally, by humanitarian medical officers attached to the military troops that were sometimes stationed there. Obstetrics was practiced by midwives, called "granny women." Cabinet makers and carpenters sometimes claimed proficiency as "bonesetters," and minor surgery was often performed by village barbers. In the main, however, the citizens were obliged to depend upon home remedies, now known as folk medicine, for treatment of their many ills. Some of these ministrations were so crude and harmful, according to modern standards. that their use was nothing short of tragic. As a result, the death rate was extremely high.

Judge Shake graduated from the Indiana University School of Law in 1910 and has had a distinguished career in practice and on the Bench.

He served as Executive Presiding Judge, U. S. Military Tribunals and as Presiding Judge in the I. G. Farben Case, Nurenberg, Germany, 1947-48.

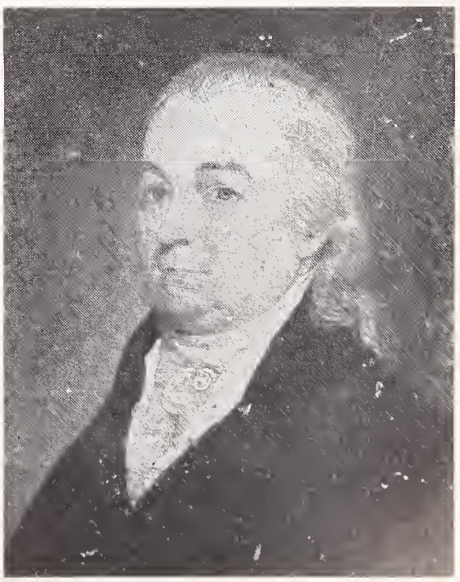
In addition to serving on a number of Presidential Emergency Boards, he has served as referee for the National Railroad Adjustment Board in over 1,200 labor disputes from 1945 to the present, also serving as a member of the U.S. Railway Labor Panel 1945-48. He was a United States Commissioner from 1917 to 1921.

From 1948 to 1966 he served as president of the Board of Trustees of Vincennes University, as Indiana State Senator in 1927, and as Judge of the Supreme Court of Indiana from 1938 to 1945.

The First Resident Physician in Indiana

The first resident physician in Vincennes and in what is now the state of Indiana was Dr. Elijah Tisdale. A native of North Carolina, he was commissioned a Surgeon's Mate by President George Washington at Philadelphia, then the nation's capital, on March 4, 1791. Assigned to the Second Infantry of the U.S. Army, he was sent with the troops to Post Vincennes the following year. In 1796, he resigned his commission and was thereafter engaged in the private practice of his profession at Vincennes until his death in 1807.

Nothing is known about Dr. Tisdale's medical training, but the fact that he had in his private library such standard authorities as Cullen's *Practice of Medicine*, Bell's *Surgery*



Dr. Elijah Tisdale

and Hamilton's *Obstetrics* indicate that he was well qualified.

Dr. Tisdale married the daughter of Capt. Francois Busseron, a prominent French citizen of Vincennes, and he resided on the Wabash River bank at the end of what is now Sycamore Street, in property that is now a part of the Vincennes University campus. There is a fine oil portrait of him, painted on a wood board, in the collection of the Chicago Historical Society and it is reproduced herewith by permission of that organization.

About the time of the death of Dr. Tisdale a number of other competent physicians located in Vincennes. Among these were Doctors Jacob Kuykendall, Elias McNamee and Samuel McKee.

The First Medical Society in Indiana

Prior to Indiana's admission into the Union in 1816 it had no laws regulating the practice of medicine. There was nothing to prevent ignorant and unscrupulous persons from holding themselves out as physicians and many such did so. On December 24, 1816, the first Indiana General Assembly, in session at Corydon, the state capital, adopted "An Act to regulate the practice of Physic and Surgery." This act provided for a board of censors in each of the three judicial districts of the state. Those named for the first district were Elias McNamee, Jacob Kuykendall, David M. Hale, Thomas Polke, and Joel F. Casey, all of Vincennes. These men met at the tavern of Peter Jones in Vincennes on June 2, 1817, and organized as the "First District Medical Society." This was the first medical society in Indiana. It had authority to examine and license applicants for admission to the medical profession and to expel members who were guilty of intemperance or immorality. It met regularly at Vincennes and discharged its responsibilities in a most acceptable manner. Among the progressive steps that it sponsored were the formation of a District Pharmacopeia and support for a National Vaccine Institution. An article in the Transactions of the Indiana State Medical Society for the year 1874 paid the following tribute to this pioneer organization:

> "This society was the 'Mecca' at whose shrine, in springtime and in autumn, the professional pioneers of our state came from the hamlet, from the prairie, and from the shadowy and lonely forest, to offer their devotions to medicine and kindred sciences. The paths leading hither were untrodden. They were long and weary, but at the end their noble purposes were strengthened and their faith and knowledge renewed."

In 1832, the name of the First District Medical Society was changed to the "Vincennes Medical Society" and, again in 1875, to the "Knox County Medical Society." Under the latter name it is still in existence and it may proudly claim the distinction of being the first and oldest medical society in Indiana.

The First Medical Book Produced in Indiana

The first medical book produced in Indiana was written by a Vincennes physician and published by a

THE

SICK MAN'S COMPANION,

OR

THE PRESERVER OF HEALTH,

TREATING DISEASES COMMON TO THIS COUNTRY,

ACCORDING

TO THE MOST SUCCESSFUL PRACTICE.

TO WHICH IS ADDED A SHORT AND COMPREHENSIVE DESCRIPTION OF THE MEDICINES USED IN THE PRACTICE,

AND THEIR DOSES,

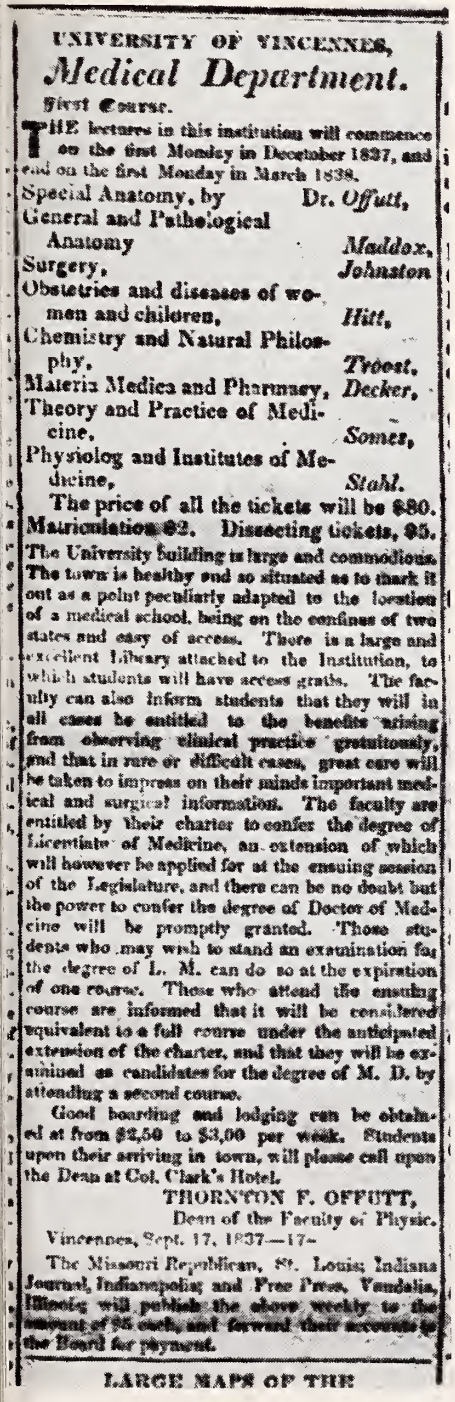
By DR. C. VANHOOK,
OF VINCENNES, STATE OF INDIANA.

VINCENNES, INDIANA:
E. STOUT PRINTER, OFFICE OF THE "WESTERN SUN."

1832.

TITLE page of the first medical book written and published in Indiana.

Vincennes printer in 1832. The author was Dr. C. Vanhook and the printer was Elihu Stout, proprie or of "The Western Sun," Indiana's pioneer newspaper. The title of the book was, "The Preserver of Health, treating diseases common to this country, according to the most successful practice. To which is added a short and comprehensive description of the medicines used in the practice, and their doses." It consisted of 72 pages, plus an index. The



UNIVERSITY OF VINCENNES,

Medical Department.

First Course.

THE lectures in this institution will commence on the first Monday in December 1837, and end on the first Monday in March 1838.

Special Anatomy, by Dr. *Offutt*,
General and Pathological Anatomy *Maddox*,
Surgery, *Johnston*
Obstetrics and diseases of women and children, *Hitt*,
Chemistry and Natural Philosophy, *Troost*,
Materia Medica and Pharmacy, *Decker*,
Theory and Practice of Medicine, *Somes*,
Physiolog and Institutes of Medicine, *Stahl*.

The price of all the tickets will be $80. Matriculation $2. Dissecting tickets, $5.

The University building is large and commodious. The town is healthy and so situated as to mark it out as a point peculiarly adapted to the location of a medical school, being on the confines of two states and easy of access. There is a large and excellent Library attached to the Institution, to which students will have access gratis. The faculty can also inform students that they will in all cases be entitled to the benefits arising from observing clinical practice gratuitously, and that in rare or difficult cases, great care will be taken to impress on their minds important medical and surgical information. The faculty are entitled by their charter to confer the degree of Licentiate of Medicine, an extension of which will however be applied for at the ensuing session of the Legislature, and there can be no doubt but the power to confer the degree of Doctor of Medicine will be promptly granted. Those students who may wish to stand an examination for the degree of L. M. can do so at the expiration of one course. Those who attend the ensuing course are informed that it will be considered equivalent to a full course under the anticipated extension of the charter, and that they will be examined as candidates for the degree of M. D. by attending a second course.

Good boarding and lodging can be obtained at from $2,50 to $3,00 per week. Students upon their arriving in town, will please call upon the Dean at Col. Clark's Hotel.

THORNTON F. OFFUTT,
Dean of the Faculty of Physic.

Vincennes, Sept. 17, 1837—17-

The Missouri Republican, St. Louis; Indiana Journal, Indianapolis; and Free Press, Vandalia, Illinois will publish the above weekly to the amount of $5 each, and forward their accounts to the Board for payment.

LARGE MAPS OF THE

PUBLIC announcement of the opening of the first medical school in Indiana, 1837.



HOME of Vincennes University, 1811 to 1839, where the first medical school in Indiana was conducted.

author discusses "intermittent fevers" and "remitting fever," inflammations, burns and toothache, and has a section on materia medica and botany. A copy of this rare publication is in the William Henry Smith Memorial Library of the Indiana Historical Society at Indianapolis.

The First Medical School in Indiana

Vincennes University was incorporated by the first General Assembly of the Indiana Territory on November 29, 1806. Its charter authorized the appointment of professors of Divinity, Law and Physic, and the conferring of such degrees in the liberal arts and sciences as were usually conferred by other universities in the United States. No effort was made to provide professional training until the year 1837, however, when the Vincennes Medical Society petitioned the trustees of the University to establish a medical department. This was the first bonafide effort to provide medical training in Indiana, although an unauthorized "diploma mill" at Madison had previously assumed to confer medical degrees for a price and without any educational requirements.

The trustees of the University acted favorably on the medical society's petition and, on September 17, 1837, announced in the Vincennes papers, the St. Louis Republican, the Indianapolis Journal and the Vandalia Free Press that its Medical Department would open to students on the first Monday of December 1837, and that the course would continue until the first Monday of March 1838. The announcement read:

"The price of all the tickets will be $80. Matriculation $2. Dissecting tickets, $5. The University building is large and commodious. The town is healthy and so situated as to make it out as a point peculiarly adapted to the location of a medical school, being on the confines of two states and easy of access. There is a large and excellent library attached to the Institution, to which students will have access gratis. The faculty can also inform students that they will in all cases be entitled to the benefits arising from observing clinical practice gratuitously, and that in rare or difficult cases, great care will be taken to impress on their minds important medi-

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Good boarding and lodging can be obtained at from $2.50 to $3.00 per week. Students upon their arriving in town, will please call upon the Dean at Col. Clark's Hotel."

The University assembled an outstanding medical faculty:

Dr. Thornton F. Offutt, Dean and Professor of Special Anatomy

Dr. Joseph Maddox, Professor of General and Pathological Anatomy

Dr. Willis W. Hitt, Professor of Obstetrics and Diseases of Women and Children

Dr. Benoit Troost, Professor of Chemistry and Natural Philosophy

Dr. Hiram Decker, Professor of Materia Medica and Pharmacy

Dr. Joseph Somes, Professor of the Theory and Practice of Medicine

Dr. Daniel Stahl, Professor of Pathology and Institutes of Medicine

That the school got off to a good start is indicated by the following editorial comment in the *Vincennes Western Sun and General Advertiser* of December 9, 1837:

> "The Lectures in the medical college of this place commenced on Monday last, and I am gratified to state, that so far as I know they have been well attended. I know not the number of students. Not being able to attend myself, I can only speak of them from common report; and receiving that as true, in this case, they have been creditable to the Lecturers and of Advantage to the Auditors. They have my best wish."

No list of the students who attended or finished the initial course of the University's Medical Department has been found. It may be assumed, however, that the results were considered satisfactory because on June 28, 1838, the Vincennes Medical Society addressed a formal petition to the University's board of trustees requesting that a medical faculty be again appointed. The trustees looked with favor on this request but were obliged to reject it on account of more serious problems. The University was heavily in debt and found it necessary to sell its campus and fine building to meet its financial obligations. Deprived of its physical plant, the University was obliged to abandon its effort to maintain a medical department. This brought to a close the initial undertaking for a medical college in Indiana.



HISTORICAL marker to the left of the building proclaims this to have been the first hospital in Indiana.

The First Hospital in Indiana

In the year 1836 there migrated from France to Vincennes a young physician, surgeon and dentist by the name of Jean Isadore Baty, who became better known as Dr. John Baty. He had graduated with high honors from the Medical School of Paris at the age of 22 and had been offered a position on its faculty but decided to come to America instead, on account of the unsettled condition of his native country.

Dr. Baty soon established an enviable reputation in the medical profession at Vincennes and was especially skilled as a surgeon. About 1840 he acquired a sizeable tract of land at the southeast corner of Second and Shelby Streets and erected thereon a large and substantial brick building, especially designed to serve as a hospital. He maintained his residence at the east end of this structure and behind it and extending back as far as Fifth Street were his extensive gardens, vineyards and orchards.

About 1866, Chauncey Rose, the Terre Haute philanthropist, built a

hospital in that city to be operated by a Catholic order and employed Dr. Baty to head it. After serving in that capacity for a number of years, he returned to Vincennes for a short time and then retired to California, where he died. A contemporary, himself a distinguished physician, wrote in 1874 in a published sketch entitled "A Medical History of Vincennes," this tribute to Dr. Baty:

> "On account of his superior attainments in medicine and surgery, his learning and high moral qualities, I think he deserves a special notice in this report. While here he performed many important surgical operations and enjoyed the full confidence of a large circle of friends and acquaintences."

The hospital that Dr. Baty built more than a century and a quarter ago still stands in old Vincennes. Though sadly neglected it is yet a sturdy structure and has the appearance of a bit of old Paris transplanted to the banks of the Wabash. Its historical significance is the fact that it was the first hospital in Indiana.

The First County Hospital in Indiana

The sound of the siren on an ambulance, heralding that some injured or afflicted person is being taken to the hospital, is so frequent that it is difficult to recall the conditions that existed before there were such institutions. Barely more than fifty years ago there were few public hospitals outside the metropolitan centers. If a stranger were stricken in the average community, there was no place to which he could be taken other than the jail, the poorhouse or the pest farm.



IN 1908 the Good Samaritan Hospital at Vincennes became the first county hospital in Indiana.

Such were the conditions in Vincennes when the civic consciences of its citizens were pricked by a series of such unfortunate incidents. A local newspaper reported that:

"For an hour this morning, the bruised and mangled body of a man lay at the Union Station in sight of all who passed because there was no suitable place to take him."

About the same time the arrival of a prominent lady at her club meeting was delayed by the confusion that ensued when a personable young man, a stranger in the community, suffered an apparent heart attack on Main Street and was carried away to the county jail because there was no other place to care for him. These were the circumstances that induced the Columbian Reading Circle to undertake the task of sponsoring a movement for the establishment of a county hospital. In the beginning their efforts were modest and oft-times unrewarding. By means of such enterprises as rummage sales, baby shows and auctions they finally accumulated a fund of $300, which they tendered to the city council to encourage and assist it in acquiring a city block as a site for the proposed hospital. The city responded with an appropriation of $7,000 and the site was purchased.

The next step was to persuade the county council to appropriate $25,000 for the construction of a building. In this appeal the ladies had the warm and helpful support of the County Sheriff, Abe J. Westfall, who shared their view that a jail was no fit place for those needing medical service and nursing care.

And so it was that on February 8, 1908, the first county hospital in Indiana opened its doors. As a part of its public service the Good Samaritan Hospital also inaugurated the first nurse's training school in the state to be sponsored by a county

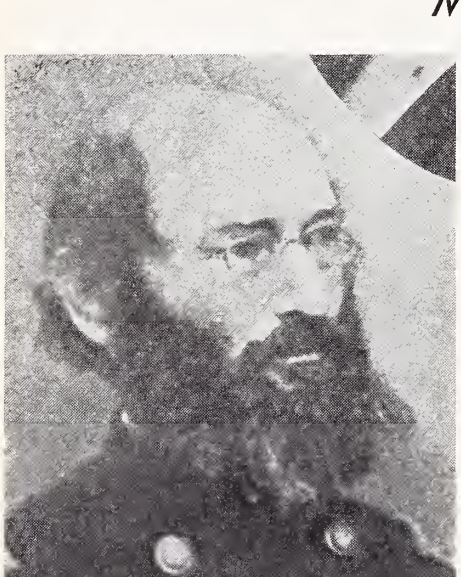


THIS modern structure houses the nursing department of Vincennes University.

supported hospital. In 1961 the administration of this school was taken over by Vincennes University and it became the pilot program for the two-year training course for registered nurses in Indiana.

The University's department of Nursing Education has been operated in a temporary building, originally the WAC headquarters at the George Field Air Force Training Base in Illinois, but in September of this year the school occupied a new and one of the most modern facilities of its kind in the county.

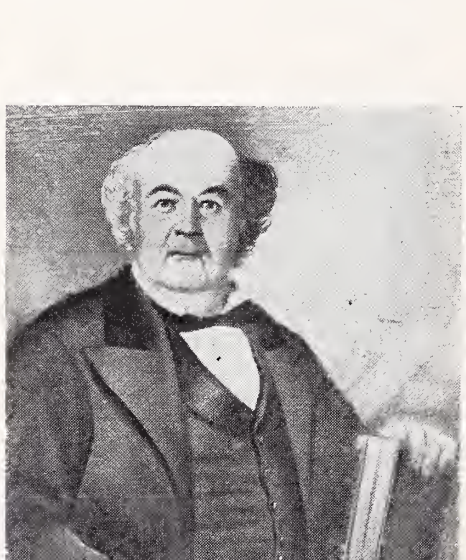
The Faculty of the Vincennes University Medical School, 1837-1838



Dr. Daniel Stahl

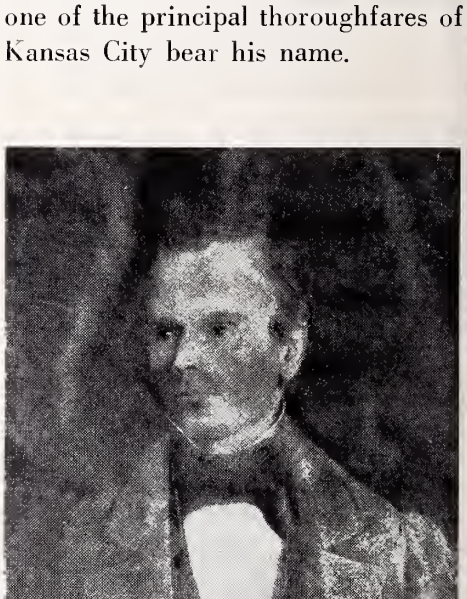
Dr. Daniel Stahl—Professor of physiology and institutes of medicine, was born in Gilserberg, Germany, in 1807. He was educated at the universities of Munich, Vienna and Marburg, where he was a fellow student of Pilissier. He came to America in 1832 or 1833, and spent some time in Philadelphia in the further study of medicine and English. In 1835 he settled in Vincennes where he married Theresa De Houle, whose grandfather had accompanied Gen. Lafayette to America.

Dr. Stahl practiced at Vincennes until 1841, when he moved to Quincy, Ill. On the establishment of the medical department of Illinois College at Jacksonville, he was given the chair of Professor of the Theory and Practice of Medicine. In the cholera epidemic of 1849, his wife was one of the first victims. Among his medical publications were, "*Sulphate of Quinine in the Congestive Modifications of Scarlet Fever*," and "*Sectional Teaching of Medicine*." He was one of the founders of the Illinois Medical Society, but retired from the practice in 1857 to place his children in Swiss schools. On the outbreak of the Civil War he returned to America and served for five years as an army surgeon, rising to the rank of Colonel. He died at Baden Baden, Germany, in 1874 and is buried there.



Dr. Benoit Troost

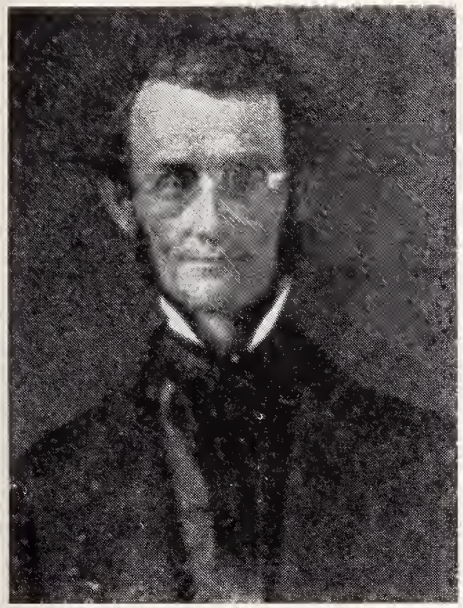
Dr. Benoit Troost—Professor of chemistry and natural philosophy, was born in Holland in 1786. He graduated with the highest honors from the University of Paris and served for a time as a surgeon in the French army. In 1809 he came to America with his brother Gerard, a graduate in pharmacy at the University of Amsterdam and in medicine at the University of Leyden. Gerard joined Robert Owen's educational experiment at New Harmony, Ind., and later gained the reputation of the "Agassiz of the South" as state geologist of Tennessee. Dr. Benoit Troost first located at Carlisle, Ind., but moved to Vincennes in 1837. In addition to practicing medicine he operated a distillery which was located where Vincennes University now stands. In 1845 he moved to Independence, Mo., where he established a reputation as an outstanding physician. He became wealthy and was an unsuccessful candidate for Congress in 1853. He died in 1859 and a public park and one of the principal thoroughfares of Kansas City bear his name.



Dr. Joseph Somes

Dr. Joseph Somes—Professor of theory and practice of medicine,

was born in England in 1801 and came to America in 1826. In 1829 he graduated in medicine at Transylvania University, Lexington, Ky., and located at Vincennes soon thereafter. He married the daughter of Judge Henry Vanderburgh, one of the first judges of the Northwest Territory. For 40 years Dr. Somes was a prominent physician and leading citizen of Vincennes. He was a trustee of Vincennes University and was actively identified with many civic organizations. In 1872 he removed to Leavenworth, Kan., and died there a few months later, but was buried in Vincennes.



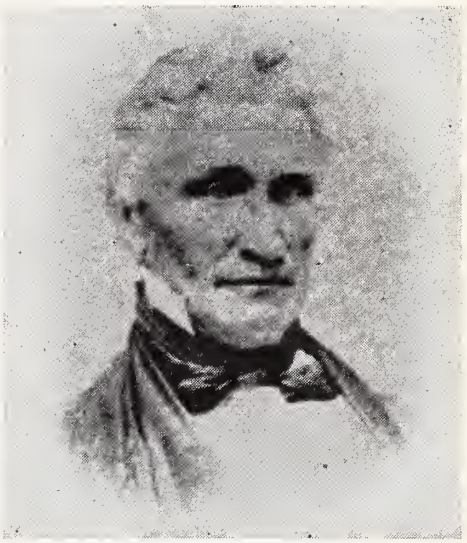
Dr. Willis W. Hitt

Dr. Willis W. Hitt—Professor of obstetrics and diseases of women and children, was born in Kentucky in 1801. He graduated in medicine at the University of Maryland in 1829, and practiced in the hospital there for a time. In 1829 he came to Vincennes where he practiced the remainder of his life. He was eminently successful and once removed a large tumor from a woman's breast at her country home, without any assistance or the use of any anesthetic, an accomplishment that attracted much attention in the medical journals of the day. He was a member of the Indiana Constitutional Convention of 1850 and served as a trustee of both Vincennes University and Asbury College, now DePauw University. He died at Vincennes in 1876.

Dr. Joseph Maddox—Professor of general and pathological anatomy, was born at Danville, Ky., about 1808. His father, Dr. John Willis Maddox, was a native of Virginia and is believed to have studied under the celebrated Dr. Ephriam McDowell of Danville. About 1812 the father migrated to Gibson County, Ind., where he married Jane Montgomery Warrick, the widow of Capt. Jacob Warrick who was killed at the Battle of Tippecanoe. Dr. Joseph Maddox operated a drug store in Vincennes for a time and was licensed to practice medicine there on May 7, 1832, by the Vincennes Medical Society. About 1839 he retired from practice on acount of ill health and removed to Gibson County, Ind., where he died in 1842. (No portrait available.)

Dr. John W. Johnston—Professor of surgery, was born in Virginia and graduated from the medical department of the University of Pennsylvania in 1814. During the time he served on the medical faculty of the University he was in partnership with Dr. Offutt, the dean of the school. Apparently, he left Vincennes shortly after the closing of the school and the writer has been unable to ascertain what became of him. (No portrait available.)

Dr. Thornton F. Offutt—Dean and professor of special anatomy, is thought to have come to Vincennes from Kentucky. He enjoyed an extensive practice and was active in civic and educational affairs. In addition, he gave popular lectures on phrenology. Where he obtained his medical education or where he went when he left Vincennes shortly after the close of the medical school is unknown to this author. (No portrait available.)



Dr. Hiram Decker

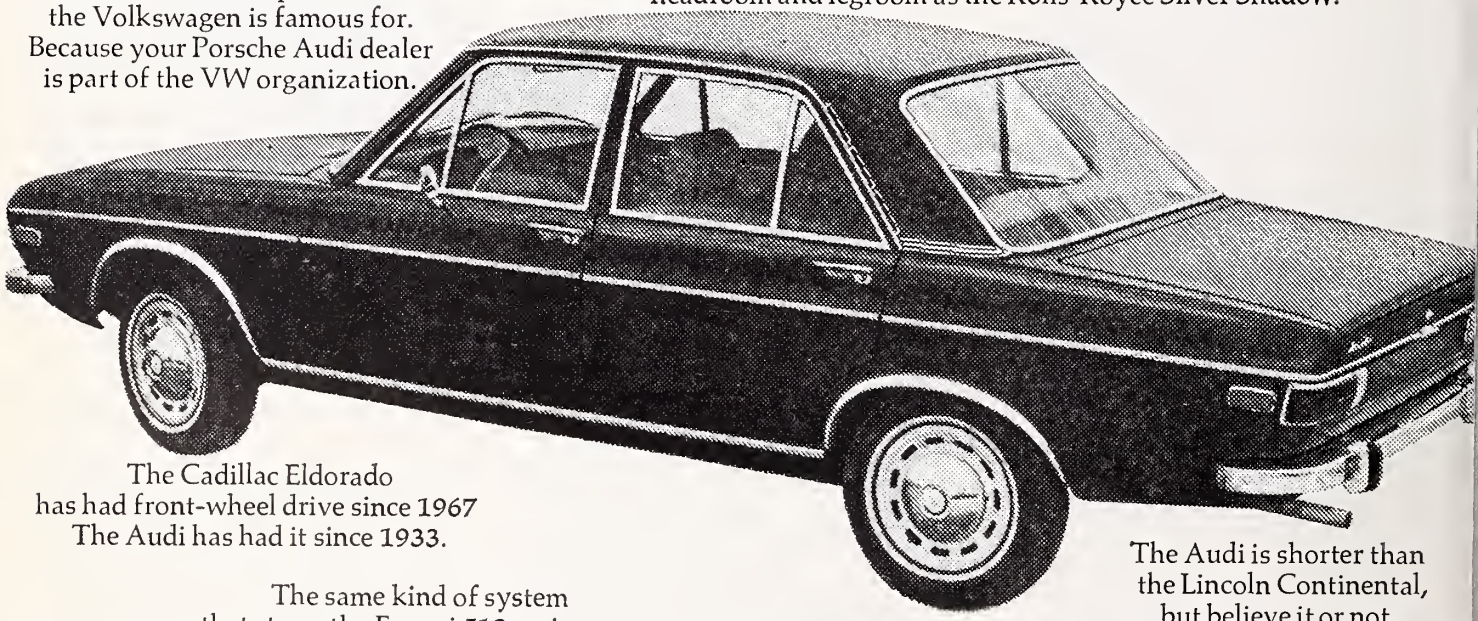
Dr. Hiram Decker—Professor of materia medica and pharmacy, was born in Vincennes in 1794. He received a good education at Vincennes University, of which his father was one of the original trustees, and studied medicine under Dr. Jacob Kuykendall, one of the pioneer physicians of Vincennes. Dr. Decker was a prominent physician and leader in the life of Vincennes for more than a half century. He was with General Harrison at the Battle of Tippecanoe and was also a trustee of Vincennes University. A fiery individual, he once took offense at the remark of a friend, which he thought reflected on his honor. He drew a sword from his cane and severely wounded his friend. Stricken with remorse, he carried his friend to his office and spent the night nursing him beyond the point of danger. The doctor died at Vincennes in 1863, a highly respected old man.

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it has just as much trunk space.

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Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause *CNS effects* such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic *cardiovascular effects* reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. *Allergic phenomena* reported include such conditions as rash, urticaria, ecchymosis, and erythema. *Gastrointestinal effects* such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libida, dysuria, and polyuria.

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Specific therapy for night leg cramps

Evaluation of the Plain Roentgenogram of the Abdomen in Diagnosis of Abdominal Disease

MALCOLM S. FLOYD, M.D.
Vincennes*

THE purpose of this paper is to present a practical method of evaluating films of the abdomen. But it is not for the radiologist. It is designed to aid the busy surgeon or attending physician who has the problem of evaluating patients with acute abdominal problems in emergency conditions. For the purpose of this paper, only flat plates are used; however, it is recognized, of course, that further evaluation with upright or decubitus or inverted views may be indicated. Barium studies may be required at times to ultimately resolve the diagnosis.

A practical, orderly way of observing the flat plate, would be to consider the various contents of the abdomen and for this purpose we shall classify them into five groups:

Group I: Air inside the intestinal tract.
Group II: Air outside the intestinal tract.
Group III: Abnormal soft tissue shadows.
Group IV: Intra-abdominal calcifications.
Group V: Osseous structures.

Obviously, an occasional film will demonstrate more than one of these findings. Before discussing abnormalities seen on a plain film, the various aspects of the appearance of a normal film should be considered. The normal soft tissue configuration of the liver, spleen, kidneys, and the ileo-psoas should be known before intra-abdominal soft tissue masses or displacements or abnormal locations of normal organs can be considered. Again, the normal distribution of gas in the intestinal tract for various ages and physiologic stages should be considered before one can definitely recognize intestinal obstruction.

Normally, gas is seen in the large bowel and in the stomach. Some gas may be observed within the small bowel and larger quantities of gas within the small bowel may be seen in air swallowers and this may be of no significance. However, this does make us consider the possibility of obstruction or paralytic ileus. In general, gas within the bowel to a certain level indicates that an obstruction is present at this level. The normal contours of the large and small bowel are different and, in the normal or early abnormal stage, this delineation may be retained; however, when these two are considerably distended, differentiation between large and small bowel may be impossible. The plicae circulares of the small bowel are different from the haustral folds of the colon.

The psoas outlines are usually fairly well demarcated, as are the kidneys. It is to be recalled that the left kidney may be lower than the right normally, and also that both kidneys may be low-lying without implication that pathology is present. Both are usually visible, although fecal material can obscure one or both.

The liver and spleen can often be seen. Laterally, a Reidel's lobe is often low-lying due to development. Ordinarily, no air is seen between the diaphragm and the liver proper, however this may be observed in interposition of the colon between right hemidiaphragm and liver (no clinical significance) or this may also be due to free air which outlines the falciform ligament. Upright views of the abdomen will quickly resolve whether this is free air or due to interposition. The liver may be truly enlarged, however, both the liver and spleen may be low-lying in patients with emphysema. The spleen, likewise, may be seen to be enlarged in hypersplenism and due to other causes.

General considerations and clinical evaluations are taken into account before a scout film (flat film) is obtained. Enemas are contra-indicated because this may alter the appearance of the gas and introduce gas into the colon and may make an obvious obstruction non-diagnosible. Upright, inverted or decubitus views of the abdomen should be obtained after the flat, if an early obstruction or free air is suspected. The left lateral decubitus view (left side down) is, in general, more helpful than the right lateral decubitus view for evaluation for free air, if the

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upright cannot be obtained. In a complete small bowel obstruction, there will be no gas within the bowel beyond the point of obstruction and air fluid levels will usually be present on upright view which are usually arranged in a "ladder" pattern. If the obstruction is incomplete, diagnosis will be more difficult and gas will be present within the colon. However, in these instances with other views laddering is also usually present within the small bowel, and the diagnosis of a small bowel obstruction could be suspected. If there is difficulty in determining whether or not this is a large or small bowel obstruction, a barium enema could be performed. Barium should never be given by mouth if there is a clinical possibility of a bowel obstruction. A barium enema will delineate colon obstruction. Digital examination of the rectum should be done on these patients and proctoscopy or sigmoidoscopy may be indicated following the preliminary plain film of the abdomen. A Fleet enema may be helpful in preparation.

I. AIR INSIDE THE INTESTINAL TRACT

Small Bowel Obstruction

It is important to differentiate large and small bowel obstruction because the management of the patient may differ. The identification of obstructed loops is more dependent upon their configuration than their caliber.

Early small bowel obstruction may be manifested by a single distended loop of a closed loop appearance. Later, the distended small bowel may assume a classical ladder pattern. If the obstruction persists or is rapid in its advancement, the pattern may simulate paralytic ileus.

In very early cases, serial films may be required every few hours until the appearance changes enough to make a diagnosis. The rapidity of changes may be surprising and within a relatively short time the small bowel obstruction may become evident.

Small bowel loops are more centrally located in the abdomen than those of the large bowel and their pattern is somewhat more delicate than that of the colon where haustral folds are present. The pattern of the plicae circulares is more closely spaced and their lumen is smaller than those of the colon as a rule. The colon and the small bowel both may lose their pattern and an example of this would be volvulus. Clinically, the patient should be examined for femoral or inguinal hernia, which are the most common causes of small bowel obstruction.

Vascular occlusive disease may be present as a silent abdomen as seen with mesenteric thrombosis and this may not be definite early. Later it would present as a paralytic ileus.

Large Bowel Obstruction

Obstructed large bowel usually distends with gas proximal to the point of obstruction so that the site of obstruction can often be seen on the plain film. No gas will be evident below this point and upright or decubitus film may be helpful in evaluating for this. Again, a barium enema will give a more definitive diagnosis.

The pattern of the large bowel is more characteristic than that of the small bowel and the haustral pattern is somewhat more easily delineated. Haustral markings do not extend across the bowel lumen and they are thicker and more widely spaced and the distended bowel is usually larger. Generally, colon obstructions are accompanied with some dilation of small bowel as well.

Volvulus is most common in the sigmoid colon and here a greatly distended segment of colon will be seen and the bowel will lose its haustral pattern where dilated and a funneling or tapered appearance will be present at the point of rotation.

All intussusceptions in adults should be subjected to laparotomy—are usually associated with a polyp or tumor. They present as a mechanical obstruction.

Paralytic Ileus (Reflux—Adynamic)

Here, there is distention of both large and small bowel. This later produces fluid, and separation of the loops will occur due to free fluid within the abdomen.

In air swallowers (aerophygia) the small bowel may become filled with air, but seldom are the loops actually dilated. In ascites, the abdomen will have a generalized hazy appearance, and here the air-filled loops may be centrally located.

II. AIR OUTSIDE THE INTESTINAL TRACT

A perforated peptic ulcer is by far the most common cause of pathological pneumoperitoneum. This may also be seen in cases of ruptured diverticuli or rupture of the colon and chronic ulcerative colitis. Pneumotosis coli, a condition where air is present in the walls of the colon, is easily excluded. A recent laparotomy gives free air beneath the diaphragm and this is usually absorbed within a few days; however, occasional cases are present where the resorption may require up to one month.

A common misconception is that every case of perforated ulcer will develop a pneumoperitoneum. Actually, this is observed in only about two-thirds of the cases.

When obtaining upright or decubitus or other views, the patient should, if possible, sit upright for a minimum of five minutes to allow the air to collect.

Free air in the gallbladder implies either previous surgery on the ampulla of Vater, where the patient will have non-pathologic free air within the biliary radicles, or free air may be seen in cases where gas-forming organisms are present. The latter

is unusual. Free air usually implies that a gallstone has eroded into the small bowel and this has allowed air to collect within the biliary system.

III. ABNORMAL SOFT TISSUE SHADOWS

A subdiaphragmatic abscess is rarely seen, and yet these still occur. They may present as nothing on the routine film; however, air fluid levels may be seen. These may be associated with elevation of the diaphragm, splinting of the diaphragm or fluid in the chest. Abscesses may occur in the remainder of the abdomen and be less likely to be diagnosed. Renal and psoas outlines may be lost in paranephric abscesses or due to trauma. This may be accompanied by scoliosis with a concavity towards the lesion. Fractures may be associated with trauma.

Pelvic masses and pseudocysts of the pancreas have been seen to present as abdominal masses and ovarian and other tumors may present as abdominal masses.

IV. INTRA-ABDOMINAL CALCIFICATIONS

Many calcific densities seen on flat film have little connection with acute abdominal conditions—some of these are calcification of costochondral cartilages or phleboliths within the pelvis or spleen. Gallstones may be faceted, oval or round and may be semi-opaque. Renal stones by location are helpful in differentiating these. Appendiceal calculi occur and calculi with pancreatitis and nephrocalcinosis may be present. Areas of calcification can be seen within renal tumors. The calcification within dermoid cysts is characteristic and some other ovarian tumors calcify. If an aneurysm is sufficiently calcified, it may be identified.

V. OSSEOUS STRUCTURES

This is an important portion of the examination and the entire pathology may be here. Carcinoma and Paget's disease are examples. These may be osteolytic or osteoblastic in type or a combination of both.

Acknowledgements

Acknowledgements go to Dr. Nathaniel Ewing, Thomas Fausnacht, R. T., and Wanda Blacketer, secretary, for their aid in the preparation of this paper.

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2. *Radiologic Diagnosis of Acute Abdominal Diseases.* The Radiologic Clinics of North America, Vol. II, No. 1, Saunders, 1964.

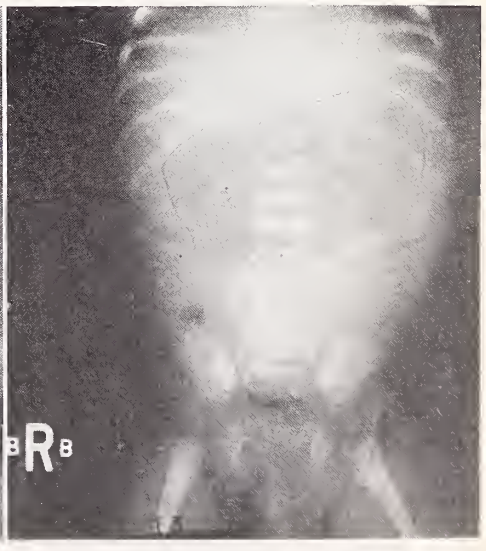
Some Representative Cases



1. 1. Sixty-seven-year-old female with air within bile ducts and gallbladder; has received Telepaque.



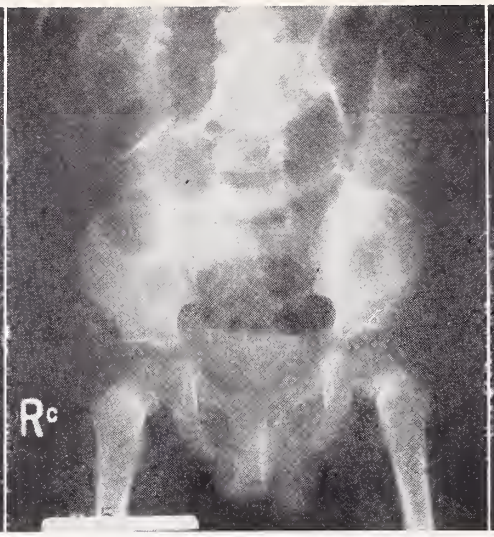
2. Seventy-five-year-old male with obstruction of sigmoid colon due to chicken bone not observed on flat film. Flat film suggested obstruction left colon.



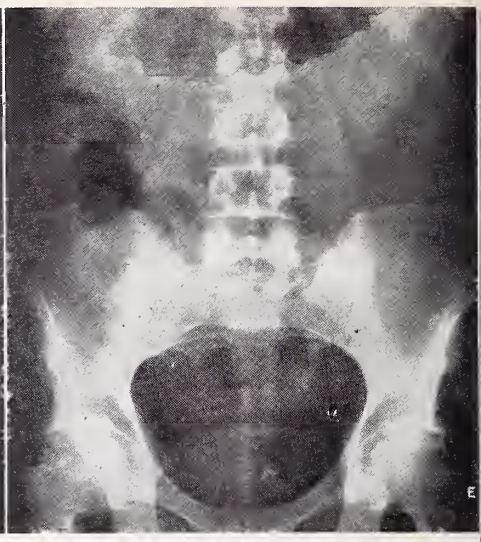
3. Five-week-old male with pyloric stenosis. Flat film suggested gaseous distention of stomach.



4. Small bowel obstruction secondary to adhesions due to previous ruptured and repaired appendix; 83-year-old male.



5. Almost complete small bowel obstruction due to Meckel's diverticulum; 2-year-old male.



6. Thirty-six-year-old male with toxic megacolon. Typical radiographic appearance of gas within granulomatous appearing colon.



7. Eighty-seven-year-old male with sigmoid volvulus. Fairly classic x-ray appearance.



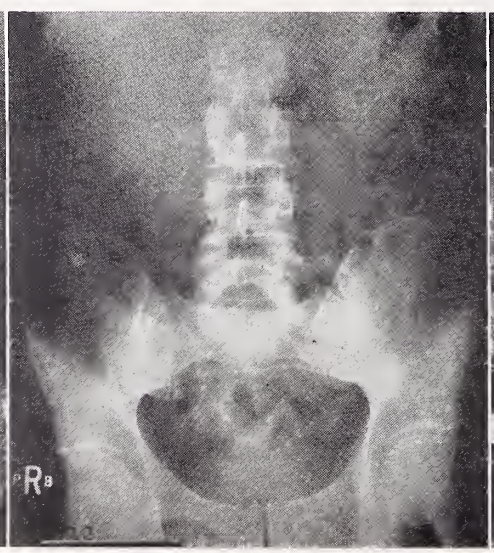
8. Sixty-three-year-old male with obstruction left colon due to diverticulitis.



II. 1. Eighty-three-year-old with free air in upper abdomen due to ruptured ulcer with air delineating falciform ligament.



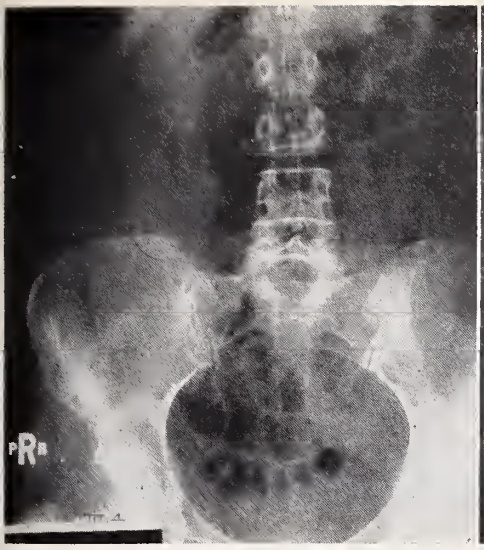
III. 1. Fifty-nine-year-old male with carcinoma, pancreas seen indenting stomach.



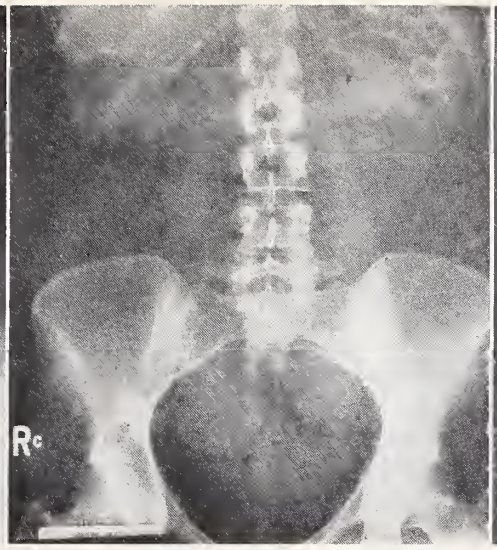
2. Fifty-two-year-old male. Hypernephroma right kidney presenting as abdominal mass. Has co-existing intrasacral meningocele.



3. Fifty-five-year-old. Huge abdominal mass.



4. Fifty-seven-year-old female with hydrops of gall bladder.



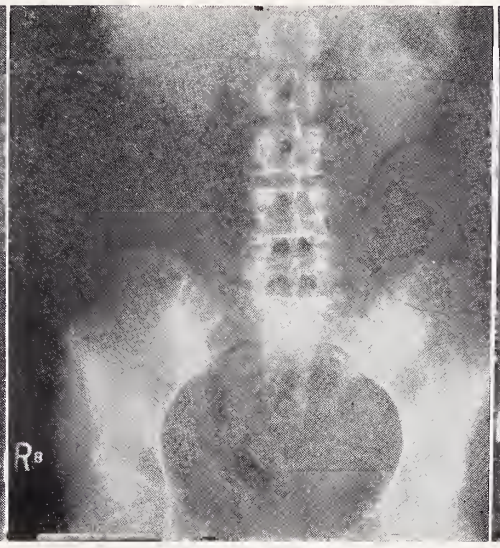
5. Thirty-seven-year-old female with bilaterally ectopic kidneys present in upper pelvis.



6. Forty-three-year-old female with large abdominal mass—proven as pseudo-mucinous carcinoma of the ovary.



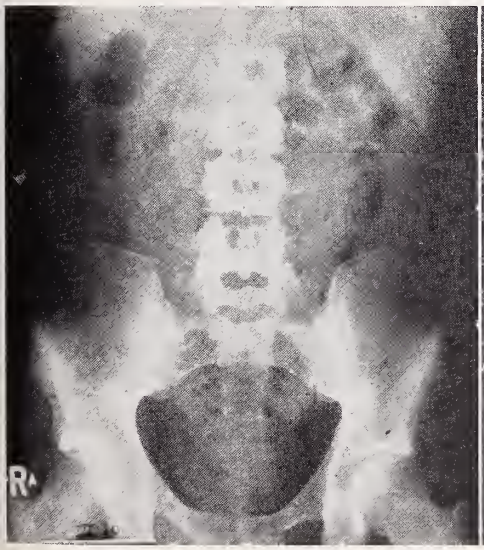
7. Forty-three-year-old female with large abdominal mass—proven to be ovarian cyst.



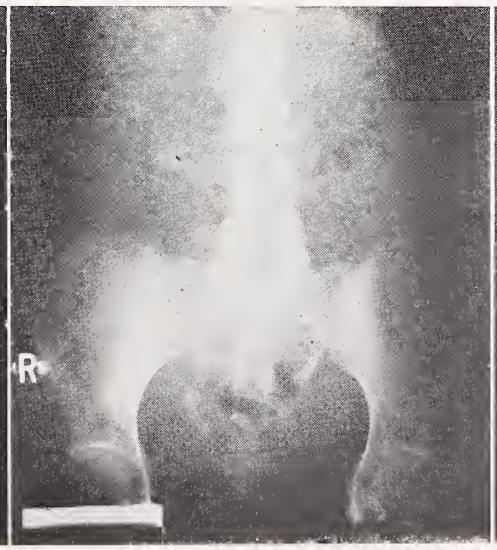
8. Forty-year-old female with abdominal mass proven to be mesenteric cyst.



9. Fifty-eight-year-old with large pseudo-mucinous cystadenoma with co-existing gall stones.



10. Contused left kidney with indistinct left psoas. Left kidney is slightly larger than right.



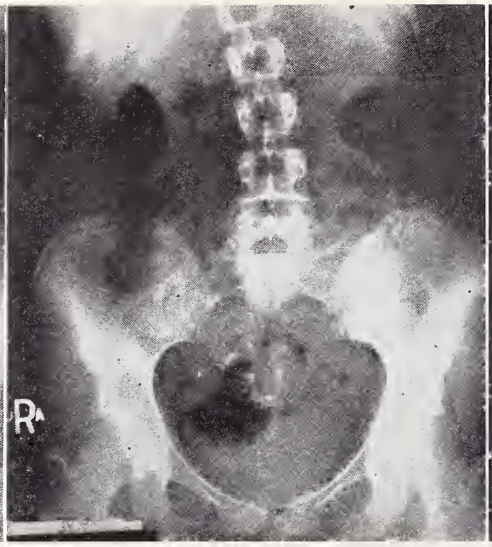
11. Twenty-four-year-old female with partial placenta previa. Fetus higher than expected. Later film confirmed.



IV. 1. Eighty-four-year-old with calcified gallbladder wall. Distention of urinary bladder.



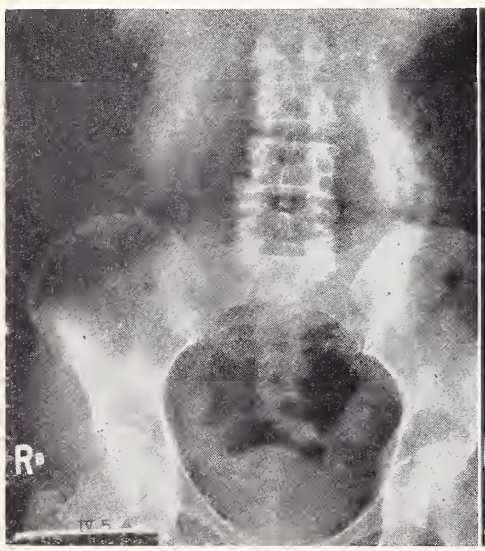
2. Fifty-eight-year-old male with pancreatic calculus and probable gallstone.



3. Twenty-year-old female with dermoid cyst of ovary. Teeth identified within dermoid.



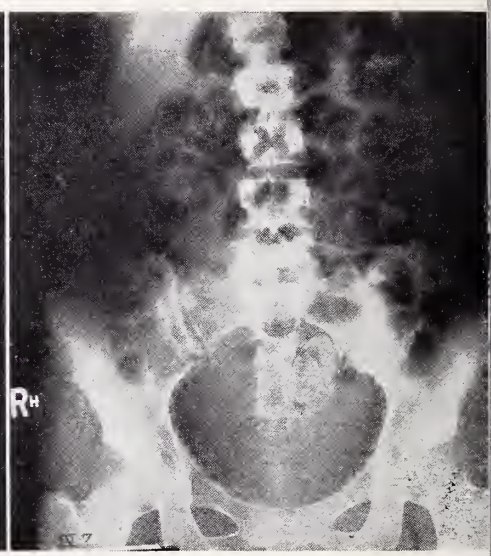
4. Seventy-seven-year-old female with gallstones and gallstone ileus.



5. Dumbbell aneurysm abdominal aorta.



6. An encephalic fetus.



7. Nineteen-year-old female showing fetal death and encarcerated fetus.



8. Seventy-eight-year-old male with dumbbell bladder stone.



9. Eighty-two-year-old with abdominal aortic aneurysm; also aneurysm of thoracic aorta.



10. Seventy-four-year-old with thorotrast within liver and spleen.



11. Fifty-one-year-old with calculus upper left ureter. Not persistently delineated because of its density.



12. Seventy-two-year-old with nephrocalcinosis.



V. 1. Eighty-three-year-old female with metastatic carcinoma to osseous structures and ascites.



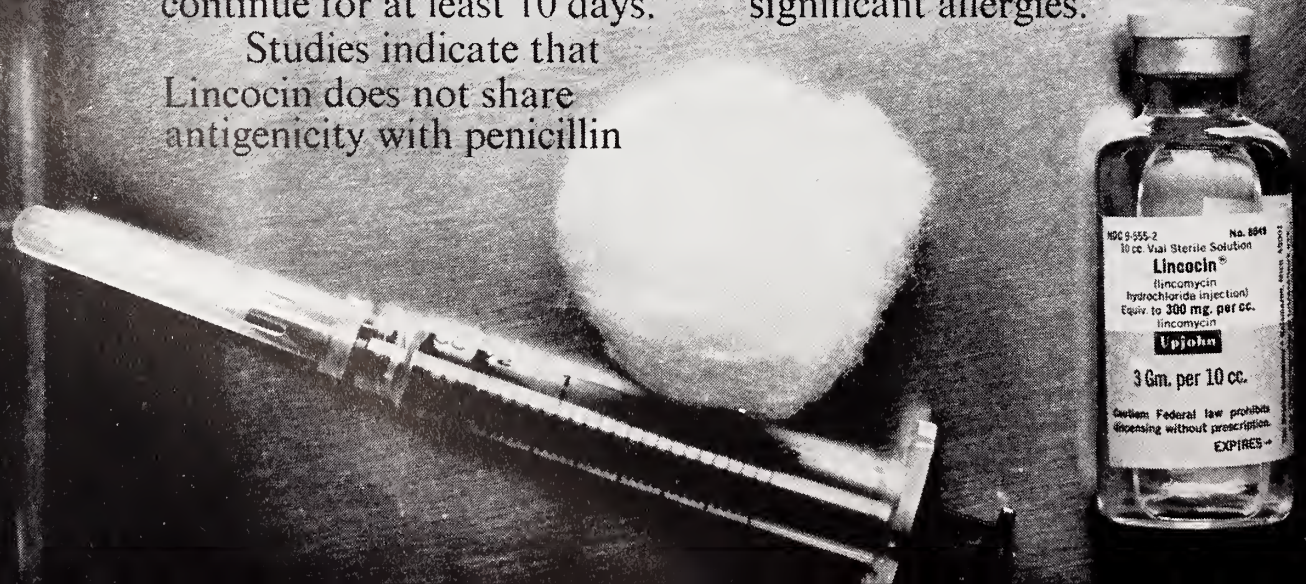
2. Seventy-one-year-old with carcinoma of prostate and diffuse osseous metastates. Prostatic calculi.

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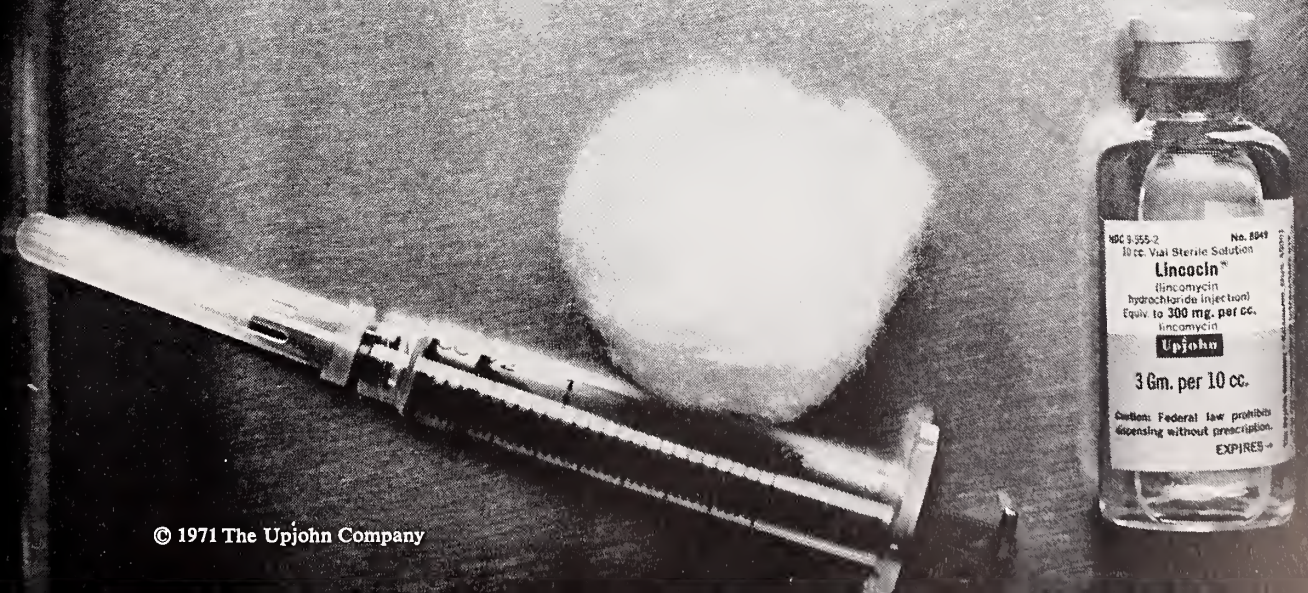
Lincocin (lincomycin hydrochloride, Upjohn) has been demonstrated to be effective in susceptible penicillinase-producing staphylococcal infections resistant to penicillin (including ampicillin). However, resistant staphylococcal strains have been recovered; resistance appears to occur in a slow stepwise manner. As with all antibiotics, susceptibility studies should be performed.

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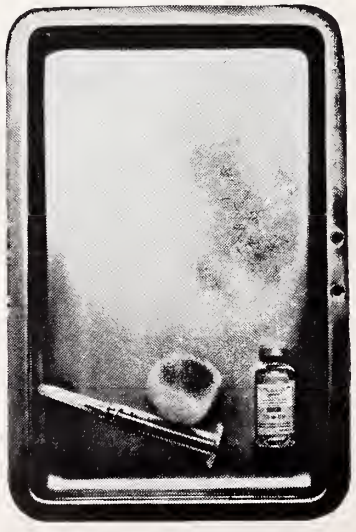
An antibiotic chemically distinct from others available, indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed.

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ADVERSE REACTIONS: *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatment. *Skin and mucous membranes*—Skin rashes, urticaria, vaginitis, and rare instances of exfoliative and vesiculobullous dermatitis have been reported. *Liver*—Although no direct relationship to liver dysfunction is established, jaundice and abnormal liver function tests (particularly serum transaminase) have been observed in a few instances.



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A Clinical Study of 2439 Surgical Procedures Performed on the Extra Hepatic Biliary Tract at the Good Samaritan Hospital between January 1, 1950 and December 31, 1970

NATHANIEL D. EWING, M.D.

WILLIAM C. VON DER LIETH, M.D.

JOHN B. ANDERSON, M.D.

Vincennes

THIS 21-year continuing study of consecutive major surgical procedures on the extra hepatic biliary tract performed on 2439 patients has been made and reported upon in two different stages. The first report was a study of those cases performed between 1950 and 1960 and this present second report reviews the entire 21-year period from 1950 through 1970. This present report also compares the morbidity and mortality experiences of the first 10 years of the study with the most recent 11 years. The study includes all types of biliary tract disease occuring outside the liver (there was one case of a choledochal cyst occuring within the liver parenchyma), although 2397 of the total operations were carried out for the removal of gallstones or the complications arising therefrom. The remaining cases were performed for such purposes as bypassing biliary obstructions due to cancer (34 cases), gall bladder and/or liver biopsy (14 cases), drainage of pericholecystic abscesses (5 cases), resections of or repairs of strictures of the common bile duct (14 cases), gall-stone ileus requiring removal of the obstructing stone from the intestinal tract (26 cases).

In the last 11 years, 85% of the cholecystectomies have been performed by these authors.

At the Good Samaritan Hospital surgical procedures on the biliary tract are the most commonly performed abdominal operations, exceeding in frequency laparotomy for removal of the appendix (982 appendectomies to 1226 biliary procedures in one 10 year period). Increasing awareness among physicians of the long term implications which gallstones present plus the frequency of such stones in the American population has contributed to our concern with the diseases of the biliary tract.

On the basis of data from the National Health Survey it is estimated that annually in the United States about 500,000 people are hospitalized for gallbladder disease and nearly two-thirds of the 500,000 hospitalized patients are operated upon each year.[1]

Recent statistics and our own studies at this hospital indicate that elderly patients are being operated upon more frequently. Two factors may explain this increase—greater acceptance of older patients for surgical therapy and increasing longevity with its concomitant increase in serious biliary tract complications. A recent and significant study on the natural history of gallstones was made by Wenckert and Robertson.[2]

This series included 1,501 persons who had either cholelithiasis or repeated non-visualization on cholecystography. Of this group 781 elected to not have removal of their gall bladder since the x-ray finding was incidental to some other problems and symptomatology was absent or minimal at the time of discovery. The condition of each of these 781 patients was then followed for 11 years. During this period over 35% developed such severe symptoms that cholecystectomy eventually was performed and a graph of the rate of increasing complications in the remaining group each year could be projected to predict that practically all survivors would eventually develop surgically mandatory complications. This doubled in the age groups over 60. The study also showed that severe complications in patients with an x-ray diagnosis of a non-visualizated gallbladder were over twice as frequent as in those who had functioning gallbladders containing stones. Much corroborative evi-

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dence can be seen in the Good Samaritan Hospital study.

The purpose of this study is to review our results at this hospital and compare our experiences with recently published results of other groups and institutions. For this reason and many others it is important to analyze the actual operative mortality, the incidence and kinds of complications and the number of and reasons for unsatisfactory results.

This group of 2439 procedures has been compared with published results covering about the same time span of Braasch, Wheeler and Colcock of the Lahey Clinic of Boston, Mass.,[3] Harshbarger and Eyerly from the Geisinger Memorial Hospital in Danville, Pa.,[4] and some of our percentages have been compared with those reported by Ferris and Sterling from the Mayo Clinic.[1] The Lahey Clinic study was selected because it represents one of the better known surgical centers which has assumed a leading position in the management of biliary tract problems. The Geisinger Memorial Hospital was selected for comparison because it is comparable in size to the Good Samaritan Hospital and, in addition, many of its patients come from rural Pennsylvania where the dietary intake of fats is high and obesity is common among farm women, just as it is in Southern Indiana. The Mayo Clinic series was selected because of the acceptable mortality and morbidity percentages reported. A comparison of the various procedures for all cases is given in Table I.

Clinical Data

The age and sex incidence of the Good Samaritan survey follows the patterns as reported numerous times. Biliary tract operations were performed 1,534 times on females and 432 times on males, or a ration of 3.5 to 1. This correlates exactly with 3.5 to 1 as reported to Colcock[5] in an older Lahey Clinic study. It is of interest to note that the male patient comes to surgery in the span of years between 50 to 79 with a peak in the 70-79 decade, while the females come to surgery most frequently in the 40 to 69 span with their peak decade between 50 to 59, almost twenty years earlier than the male. In the first 10 years of this study 22% of the patients were over 60, in the last 11 years 37.5% of the patients were over 60. This is a significant shift and increases the challenge to reduce our morbidity factors.

It is interesting to note the year-by-year increments of biliary tract procedures performed at the Good Samaritan Hospital, as shown in Table II.

In 357 cases the common duct was explored at the time of cholecystectomy, thus a choledochotomy was performed adjuntively in 15.7% of the cases. The percentage of common duct explorations at Geisinger Memorial Hospital was 18% with a 13% incidence of retained common duct stones. Our experience over 21 years would indicate an experience of only 4.04% retained common bile duct stones. Few operative cholecystograms are used but the cardinal indications for choledochotomy are adhered to—namely, jaundice or history of jaundice (chemical or clinical), dilatation concretions or thickening of the choledochus and the presence of tiny stones in the gallbladder. The retained stones in our series were recovered from four months to 22 years after a cholecystectomy. Singleton and Coleman[6] reporting on residual common duct stones found an incidence of nine percent in 159 cases of choledochotomy, while Thompson[7] reported an incidence of 11 % in 106 cases with a mortality of nine percent. We have had no postoperative deaths in our series of 92 cases of choledochotomy performed as the primary procedure.

Of the 2279 cholecystectomies, the pathological report of the specimen revealed that 1824 were performed for chronic gallbladder disease, and 373 were reported as acute cholecystitis or about a 5:1 ratio. The remaining 22 gallbladders were normal. The acutely inflammed gallbladder was also treated by cholecystostomy 82 times. This represents 18.0% of all of the acute cholecystitis cases (82 plus 373 treated by cholecystectomy). Braasch[3] reports that only 2% of the 324 cases of acute and subacute cholecystitis had cholecystostomy at the Lahey Clinic, while Ferris[1] states that only 4% of acute cholecystitis patients had a cholecystostomy.

Analysis of X-Ray Findings

The accuracy of preoperative cholecystograms can be reaffirmed in this series. In the last 10 years of this study there were 621 x-rays reviewed. These were x-rays taken at the same hospital admission as the definitive surgery. Of 306 "double dose" or "repeat" studies reported as nonfunction by the radiologist, there were 14 normal gallbladders removed or an error of 2.4% out of 321 possibilities. There were seven cases in which a normal gallbladder x-ray was reported on at least two occasions,

TABLE I

	G.S.H.	G.M.H.[4]	L.C. (acute only)[3]
Cholecystectomy	1862	612	157
Cholecystectomy with C.B.D.	357	134	144
Choledochotomy alone	92	23	0
Cholecystostomy	82	7	7
Other procedures	46	5	16
Total biliary procedures	2439	781	324

(Note: The Mayo Clinic series is reported in percentages only. See Table IV.)

TABLE II

Year	Total Adm.	Total Majors	Total Biliary Procedures	Chole-cyst-ectomy	With CBD Exp.	Percent With CBD Exp.	CBD Only	Chole-cyst-ostomy	Other
1950	5,697	863	52	48	4	8.4	3	1	0
1951	6,441	979	48	41	3	7.3	2	4	1
1952	6,981	1,062	66	52	5	9.6	7	5	2
1953	7,470	1,137	84	75	13	17.3	5	2	3
1954	7,598	1,262	96	89	19	21.3	1	3	3
1955	8,212	1,396	124	115	29	25.2	3	5	2
1956	8,708	1,605	146	134	24	17.1	3	7	1
1957	8,671	1,858	116	108	14	12.9	0	7	1
1958	9,051	1,858	137	118	16	13.5	8	9	2
1959	9,478	1,832	127	110	9	8.2	9	6	2
1960	9,570	2,014	105	97	16	16.4	3	3	2
1961	9,700	2,023	135	115	17	14.8	11	4	4
1962	9,735	2,014	90	78	5	6.4	5	4	3
1963	9,314	1,972	133	113	20	17.8	4	8	5
1964	9,416	2,109	118	109	19	17.4	3	2	3
1965	9,340	2,015	118	105	15	14.3	5	4	4
1966	9,320	1,840	135	118	21	18.6	8	7	2
1967	9,279	2,197	135	131	25	19.1	2	1	1
1968	9,461	2,233	144	139	23	16.5	5	0	1
1969	9,399	2,427	150	148	35	23.6	2	0	3
1970	9,677	2,743	138	135	19	14.0	3	0	1
Total	182,518	37,448	2,439	2,178	351	15.7	92	82	46

subsequent surgery performed on purely clinical symptomatology revealed gallstones. This gives a total error of 4.5% which can be favorably compared with an 8.2% total error for the first 10 years of the study.

Autopsy Rate

In the first 10 years of the study the autopsy rate on those patients expiring after biliary tract surgery was 55%. In the second 11 years the autopsy rate has fallen slightly. Two examples of the continued necessity of a high autopsy rate were revealed in our series. One patient was treated for acute pancreatitis because of moderately elevated amylase but at postmortem was found to have a perforated gallbladder. The other was treated vigorously as a coronary occlusion; there were elevated enzyme reports and EKG changes, but she died rapidly with an acute totally gangrenous cholecystitis (bacillary shock) and a normal heart.

Chronic Cholecystitis

Chronic cholecystitis treated by removal of the gallbladder before the age of 40 carries no mortality rate in this series. There has been no fatal outcome in the past 21 years, for 571 cases. The average overall mortality for cholecystectomy for chronic cholecystitis is .8% for all ages. This is exactly the same as the mortality rate quoted by Ferris from the Mayo Clinic.[1] Note in Table III how the mortality rate triples when cholecystectomy is performed for acute cholecystitis and how it triples again if the patient's condition requires a cholecystostomy.

Acute Cholecystitis

No discussion of this aspect of the biliary tract procedures should fail to mention that there have been 26 instances of gallstone ileus operated upon during the period of the study. Although the operative procedure in these cases was directed toward relief of the small bowel obstruction, the primary disease was an acute perforating cholecystitis. There was one death in this group of 26 patients, or a mortality of 3.46%.

TABLE III

Procedure	No. cases 1950 thru 1970	Deaths	G.S.H. Mortality from 1960 thru 1970	G.S.H. Mortality from 1950 to 1960
Cholecystectomy for chronic cholecystitis	1824	16	.8%	.8%
Cholecystectomy for acute cholecystitis	373	9	2.3%	2.4%
Cholecystostomy for acute cholecystitis	82	6	7.2%	7.5%
Total	2279	31	1.4%	

Seven of the patients with acute cholecystitis were pregnant and the attack was so severe that cholecystectomy was mandatory.

It is more than mere coincidence that elderly patients may develop an episode of acute cholecystitis during recovery from some unrelated illness. Fasting, dehydration and the resumption of food ingestion initiates the attack. Eleven patients in this series had cholecystectomies for severe acute cholecystitis following admission for some unrelated condition and developed cholecystitis after admission.

Table IV is the most significant one in this study. Herein are contained the mortality figures for the Good Samaritan Hospital compared to published results from other institutions. It is gratifying to compare the results obtained in the management of chronic cholecystitis and cholelithiasis with the published reports of other investigators, yet there is definite reason to study our complications which lead to fatalities because we have not yet reduced our mortality to the lowest reported levels.

Again it should be emphasized that the mortality rate increases about three times when the patient has to have a cholecystectomy for acute cholecystitis rather than chronic cholecystitis and increases nine times if the patient's condition is so poor that cholecystostomy is decided upon. The wisdom of proper management of acute cholecystitis cannot be obtained from these statistics since many of the patients selected for cholecystostomy might have fared worse had they had a cholecystectomy. Delaying surgery for severely acute cholecystitis for long periods of time complicated matters even further and raised the mortality rate.[3,8]

TABLE IV

Procedure	No.	G.S.H. Deaths %	G.M.H.[4] % of 674 Cases	M.C.[1] % of cases No. not given	L.C.[5] % of 324 Cases
Cholecystectomy for chronic cholecystitis	1824	16 .8%	1.3%	.9%	.5%
Cholecystectomy for acute cholecystitis	373	9 2.3%	2.0%	2.7%	.9%
Cholecystotomy for acute cholecystitis	82	6 7.2% (2 out of 6)	33%	5.0%	4.0%

Complications

The complication rate in biliary tract surgery is directly proportional to the age of the patient. In Table V notice the rapid rise in mortality and morbidity rates after the fifth decade.

This table demonstrates that the complication rate can be greatly reduced simply by earlier diagnosis and prompt surgical eradication of gallstones rather than waiting until cardiac, pulmonary and uremic conditions have complicated the problem to such an extent that the patient is less able to cope with the stress of postoperative complications. The decade of 90 to 99 has only 3 cases and is not mathematically significant.

The overall mortality rate of 2.0% includes all deaths occurring in all procedures including cancerous conditions of the biliary tree. A list of the 10 most common postoperative complications, the frequency of occurrence and the number of fatalities

MORTALITY AND MORBIDITY—EXTRA BILIARY TRACT PROCEEDINGS 1950-1967*

TABLE V

Decade	No. of cases each decade	No. of complications	% Morbidity	No. of Deaths	% Mortality
0-9	1	0	0	0	0
10-19	19	0	0	0	0
20-29	165	9	5.4	0	0
30-39	267	10	3.9	0	0
40-49	360	20	5.5	3 (15%)	.8
50-59	455	45	10.1	8 (13%)	1.7
60-69	382	49	12.9	10 (20%)	2.8
70-79	268	44	16.4	19 (43%)	6.8
80-89	55	12	21.8	9 (75%)	16.3
90-99	3	0	0	0	0
Totals for 18 years	1975	189	9.0	49	2.0

*Note: There is no mortality for patients under 40 for the 21 years of the study

associated with each complication is found in Table VI.

The list of complications experienced at this hospital parallels similar lists compiled by other institutions, with one glaring exception. So few wound infections have occurred that all records were reviewed with this complication in mind. Preventive antibiotics have been used. Studies by Ketcham[9] and by Bernard and Cole[10] and by Friend at the University of Miami have shown that tissue defenses against bacteria are established (or lost) within the first one to three hours after bacterial contamination and that factors influencing the wound response to bacteria are virtually inoperative after the time that colonization has occurred beyond 10.[8] Many other studies[11,12,13] have shown that antibiotics are indeed effective in supplementing the host defense during this initial period but are rather ineffective thereafter. On this basis many but not all patients have received intravenous broad spectrum antibiotics during the operative procedure. Interestingly enough there have indeed been few wound infections: .019%.

The most frequent and probably most preventable postoperative complications were those which arose from pulmonary problems. The operative risk of the patient with advanced pulmonary insufficiency where symptoms are florid after mild activity will be promptly recognized by all. Such a person has important advantages over the preoperative patient with insidious loss of ventilatory reserve which remains unrecognized.

The loss of ventilatory reserve associated with general surgical procedures, particularly those in the upper abdomen, has not received adequate attention by surgeons. Anscombe[14] and Kinney[15] have shown that demands for gas exchange can increase to values of 40% above the basal state while the ventilatory reserve may fall to below 50% in a patient with peritonitis, ileus and fever.

TABLE VI

Ten Most Frequent Complications Following Biliary Tract Surgery

			Frequency	Deaths
1.	Pneumonitis or atelectasis	57	.22%	11
2.	Wound disruption	44	.19%	14
3.	Ileus	19	.09%	5
4.	Urinary Retention	12	.05%	1
5.	Pancreatitis	6	.02%	3
6.	Thrombophlebitis	5	.02%	0
7.	Persistent biliary drainage	5	.02%	0
8.	Myocardial infarction	5	.02%	3
9.	Hepatitis	4	.02%	3
10.	Post-operative hemorrhage	4	.02%	2

It is in the area of a more thoughtful and careful assessment of the patient's pulmonary status that we should be able to make great strides in reducing our postoperative fatal complications. After proper assessment, the "red flag" patients should be followed by appropriate routines.

Wound disruption and the accompaning ileus, emesis, aspiration dangers have been greatly reduced in the last 10 years and all of the deaths associated with wound disruption occurred in the first 10 years of this study. In the last 11 years there have been only 9 wound disruptions (out of 38) and no deaths. This reduction in morbidity is undoubtedly due to a great mix of factors—such as techniques to prevent aspiration, prevent ileus and hiccoughs—and training all bedside personnel to recognize and report signs indicating possible dehissence.

It is the intention of the surgical service to continue a critical and analytical survey of the cumulative results of biliary tract surgery (along with other types of precedures) in order to keep patient risk at a minimum.

Summary and Conclusions

1. Extra hepatic biliary tract disease accounted for 6.5% of the total surgical procedures performed at this hospital from the first of January 1950 to the 31st of December 1970.
2. Choledochostomy as an adjunct to cholecystectomy was performed in 15.7% of the cases. The national average is that about 24% of all cholecystectomies are accompanied by exploration of the common bile duct. Despite a low exploration rate, secondary operations on the common duct to recover stones are performed less frequently than reported elsewhere.
3. The overall gross uncorrected mortality rate for the 2439 procedures is 2.0%. The highest mortality occurred in elderly patients suffering from advanced malignant disease.
4. The mortality rate for cholecystectomy for chronic calcareous disease of the gallbadder is .8%, and the mortality for cholecystectomy for acute cholecystitis is 2.3%. There have been no deaths under 40 years of age in 21 years.
5. A much higher percentage of cholecystostomies are performed at this institution than any other series studied. The mortality for cholecystostomy is three times that for cholecystectomy in handling acute cholecystitis.
6. Morbidity and mortality incidence is directly proportional to the age of the patient.
7. A clear and logical proof is made that one of the major factors in further reduction of mortality

lies in diagnosis and eradication of gallstones in the earlier decades of life.

8. Comparative study of our mortality table and complication incidence reveals that further reduction of operative risk can be accomplished. The preoperative recognition of potential pulmonary complications and their preventive management postoperatively offers the greatest area where fatalities can be avoided.

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INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—August 1971

Disease	Aug. 1971	July 1971	June 1971	Aug. 1970	Aug. 1969
Animal Bites	1305	1445	1467	1175	1221
Chickenpox	24	96	300	20	41
Conjunctivitis	138	282	171	125	122
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	20	46	28	55	21
Gonorrhea	647	834	522	753	685
Impetigo	128	176	75	190	189
Infectious Hepatitis	37	42	39	52	21
Infectious Mononucleosis	34	42	53	29	20
Influenza	279	820	351	338	272
Measles					
Rubeola	20	135	559	5	1
Rubella	51	103	520	60	38
Meningococcic Meningitis	1	1	1	3	2
Meningitis, Other	3	6	5	2	4
Mumps	57	150	510	63	93
Pertussis (Whooping Cough)	3	13	3	14	3
Pneumonia	158	286	257	220	137
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	539	580	577	418	328
Syphilis					
Primary & Secondary	20	44	25	34	27
All Other Syphilis	100	125	87	114	81
Tinea Capitis	1	0	1	5	6
Tuberculosis (Active)	47	60	58	70	82



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Carcinoma of the Prostate

NORBERT M. WELCH, M.D.
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RICHARD L. ELLIOTT, M.D.
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Incidence

THE incidence of carcinoma of the prostate, 15.7% for white and 17.4% for non-white males, causes it to be placed in the category of common diseases. Prostatic cancer in the United States ranks behind only Sweden, Switzerland, South Africa and Australia as cause of death and is the most common cause of death from cancer in the male age 75 and over.[1] Autopsy records have shown its presence in 50% of all men past 60.[2] Ten to 20% of men requiring prostatic surgery have prostatic carcinoma.

Pathology

Frequent origin of the malignancy in that portion of the gland lying dorsal to the urethra permits the examining physician an early opportunity to detect tissue change. In the early growth changes may be diffuse throughout the prostatic lobes, or as islands of malignant tissue surrounded by benign hypertrophy. Periurethral invasion and fibrosis may result in early prostatism with obstructive changes but this may not occur until after more serious metastatic growth beyond the prostatic capsule has occurred. Suspicion or diagnosis must not be deferred until symptoms appear.

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Examination

Regular and routine prostatic examination should be done. No medical or surgical examination of any male over the age of 40 years should be considered complete without a rectal examination. Patients may present themselves with typical symptoms of slow, small urinary stream with frequency and urgency. Complaints may be unlike those associated with benign prostatic hypertrophy. When the patient complains of leg pain, back pain, rectal and suprapubic pain, and occasionally of weakness, lassitude and loss of weight, extension of the neoplasm beyond the capsule should be suspected.

Prognosis

Growth of prostatic carcinoma is usually slow. The stage of growth and the degree of malignancy when diagnosed will determine patient prognosis. Early diagnosis and prompt institution of therapy, either radical surgery, hormones, and/or orchiectomy, and roentgen therapy present the best opportunity for normal life expectancy. Endocrine therapy, which is in a state of flux at this time, will usually prolong life in advanced cases of malignancy.[3,4,5,6,7] More highly malignant tumors grow faster and metastasize earlier, thus reducing the average longevity.

Differential Diagnosis

Chronic or subacute prostatitis, with glandular induration and possible periprostatic tissue inflammation, may be erroneously diagnosed as carcinoma. A history of fever, difficult urination, acute onset, urgency and frequency will help in the correct diagnosis. Acute inflammatory prostatic lesions are usually more frequent in younger men. Small areas of induration or fibrosis following glandular inflammation may be very difficult to differentiate by digital examination and may require a biopsy to rule out malignancy.

Some prostatic malignancies cannot be differentiated from benign hypertrophy on rectal examination due to tissue consistency. Endoscopic examination may afford little additional help in this type of carcinoma. Other small areas of prostatic cancer may be surrounded by benign tissue thus giving a negative digital examination diagnosis.

Endoscopy

Cystoscopy and panendoscopy will in most cases aid considerably in the correct diagnosis of prostatic cancer. Nodular irregularities of the prostatic urethra may be visible. The consistency of the gland against the endoscope or sound often permits a better evaluation of benign vs. malignant tissue. Usually a glandular malignancy which has advanced sufficiently to be detected endoscopically will be readily diagnosed by digital examination.

Roentgenology

An x-ray of the pelvis may show the presence of bony metastases. Rarely a highly malignant neoplasm may show bone change before it can be detected by rectal examination. Local pelvic extension that is easily diagnosed by rectal examination is usually present before bony metastases occur. A negative x-ray does not indicate the absence of bony metastases. The presence of malignant cells in bone marrow biopsy may precede actual roentgen changes.[8]

Laboratory Tests

The serum acid phosphatase level may be of no help until extensive bony metastases are present.

It is our purpose here to stimulate interest in annual rectal examinations to include the prostate by all physicians doing routine physical examinations. Any palpable nodule in the prostate demands urological investigation.

Classification

We have accepted the staging of cancer of the prostate as follows:[9]

Stage I is the early carcinoma of the prostate that is not detectable on routine examination. This lesion is found unexpectedly following a subtotal prostatectomy, either transurethrally or by open surgery. The acid phosphatase is normal and no bony metastases are known.

Stage II carcinoma of the prostate is an early carcinoma. A hard localized nodule is found in the prostate. There is normal acid phosphatase with no evidence of bony metastases.

Stage III carcinoma has spread into the seminal vesicles or outside of the capsule of the prostate but without evidence of distant metastases. The acid phosphatase is normal. No evidence of bony metastases is seen.

In Stage IV carcinoma of the prostate there is distant spread of the tumor. A nodular fixed prostate is found. The acid phosphatase may be elevated and there is usually x-ray evidence of metastases.

Clinical Experience and Results

Over the past fifteen years, 1956 to 1970 inclusive, we have made a diagnosis of cancer of the prostate in 519 patients. Three hundred ninety-two patients had a tissue diagnosis of adenocarcinoma of the prostate. Of the 392 patients with proven cancer, 48 were Stage I or II and were subjected to a radical perineal prostatectomy. This represents 12% with disease potentially curable by radical surgery. This is a relatively small series but we were fortunate to have had no operative mortality.

It has been our intent to treat Stage I and II carcinoma of the prostate by radical perineal in those men age 70 or less in good health. An exception will be made for the man over 70 who appears to have a potential for an additional 9- to 10-year life expectancy.

It is generally accepted that the younger the patient, the poorer the prognosis. With conservative management, the older the patient, the slower the growth of the tumor.[10]

In our series, Stage III and IV carcinomas have been treated with hormones, orchiectomy, or both.

With the publication of the VA Cooperative Study, a change in the philosophy of hormone therapy has occurred.[3] In this study it was explained that there was an increase in the incidence of cardiovascular disease and its concomitant complications in patients treated with diethyl stilbestrol for Stage III and IV cancer.

Radiation therapy to the prostate is now receiving attention from the radiotherapist and may hold promise for the future.[11,12]

Of the patients operated for Stages I and II and followed for more than five years, 75% survived without evident disease.

In our series of cases we have been able to follow 343 of the Stage III and IV cancer of the prostate patients. Two hundred twenty-two, or 64%, died in five years or less. These have not been analyzed as to the etiology of death.

Summary and Conclusions

Carcinoma of the prostate is a common disease of the male ranking high in the statistical cause of death.

The pathological site of malignant change in the prostate renders it anatomically palpable to the examining finger. There cannot be an overemphasis of the value of a rectal examination on all males over the age of 40 at least once yearly and preferably twice yearly.

Age and state of growth are important factors in the early detection of prostatic cancer and the prognosis. The younger the male, the poorer the prognosis. The older the male, the slower the tumor growth and better the prognosis. The lower the stage of classification, the better the chance for cure.

Positive diagnosis is dependent upon a pathological specimen obtained by biopsy or surgery.

The patient must be fully informed and his complete cooperation assured if a successful regimen of therapy is to be accomplished.

Radical perineal prostatectomy carries a low operative mortality and is still the best hope for cure. High voltage radio therapy seems to offer considerable promise at this time. Palliative therapy is undergoing a transition period as far as endocrine therapy is concerned until further comparative studies are completed.

We will continue doing radical perineal prostatectomies in Stage I

and II carcinoma of the prostate. Stage III and IV carcinoma will be treated by relief of urinary retention, appropriate palliative surgery and surgical castration.

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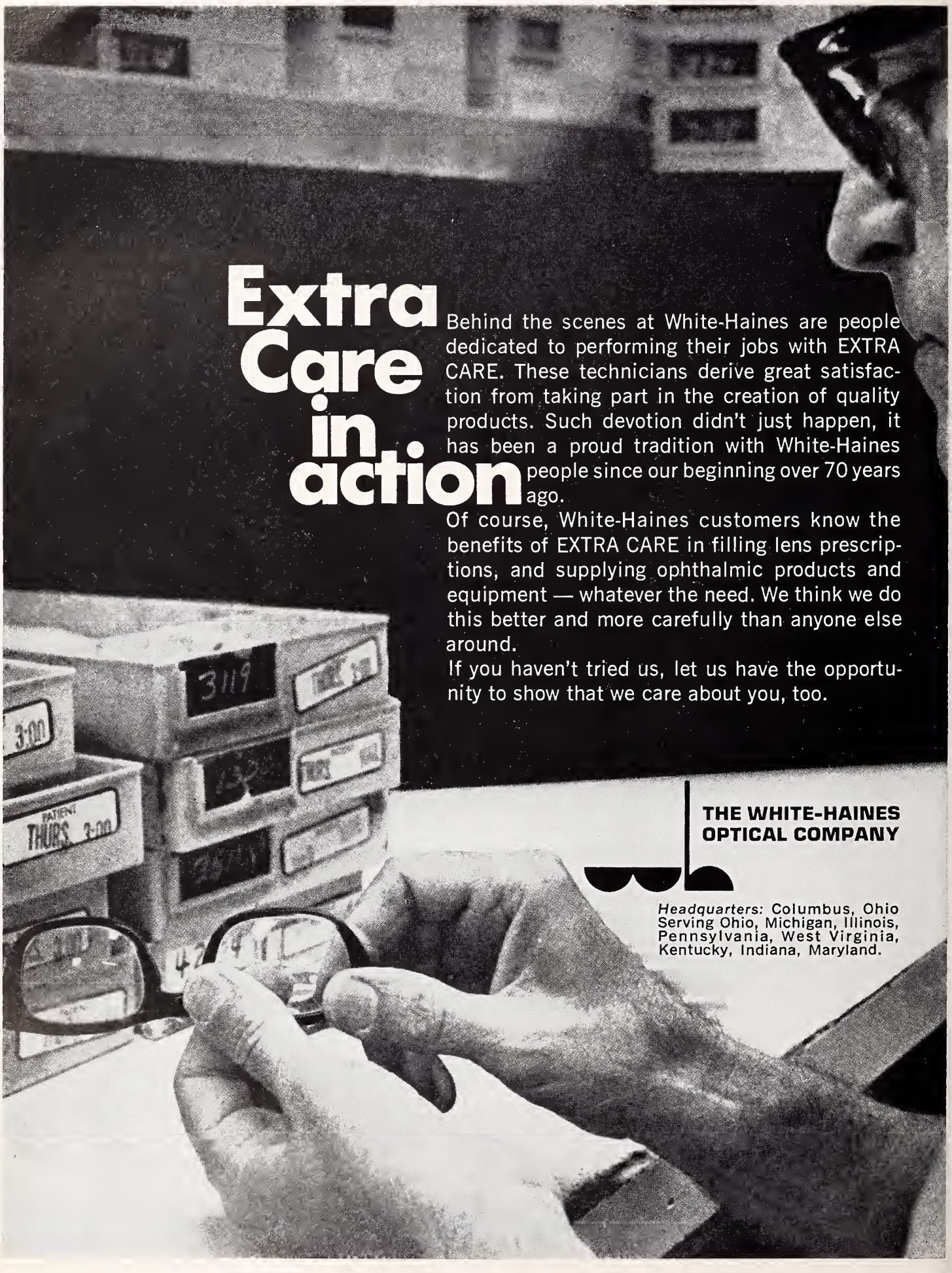
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Cryosurgery and Practical Gynecology

JOHN N. HASWELL, M.D.

Vincennes*

AT a recent convention I listened to a round table discussion on human sexuality. On the panel was a female psychiatrist-physician. Her answer to a patient's chief complaint of "a discharge" was as follows: "So what's new? Join the human race." The audience thought her remark was humorous, but I doubt that the patient was satisfied and most likely sought the services of another physician.

So what's new? Cryosurgery is new. It is a fast, painless and effective treatment for many benign diseases of the cervix, especially chronic cervicitis with its annoying, malodorous and irritating leukorrhea—the gynecologist's nemesis.

Chronic nonspecific cervicitis is a common, well defined, clinical syndrome, although its etiology is still far from fully understood. Usually the patient has urinary frequency and recurrent infections and the cervix shows a mucopurulent discharge with contact bleeding, hypertrophy, lacerations, erosion and nabothian follicles or polyps.[1]

History

The treatment of chronic nonspecific cervicitis by cryosurgery is a relatively new modality with sophisticated delivery systems utilizing liquid nitrogen or liquid freon as refrigerants.[2,3,4] Cure rates vary from 89 to 100% after a single treatment and reported complications are few.

Histologic changes of cryonecrosis are the initial sharp line of demarcation separating normal tissue from frozen tissue, followed by intense vasocongestion, leukocytic and lymphocytic infiltration, vascular endothelial sloughing and edema. Within 72 hours there is loss of cellular architecture and secondary vascular hyalinization. The regenerative process is rapid and the squamous-columnar junction is usually found deeper within the cervical canal.[5]

Materials and Methods

A Hill cryosurgical unit* was used for all procedures. Two different size cervical probes were used, the smallest 1.9 cm and the largest 2.54 cm in diameter.

A total of 80 patients received cryosurgery to the cervix for chronic cervicitis. All the patients had a class I Papanicolaou smear within six months prior to the cryosurgery. None of the patients received an anesthetic or an analgesic prior to, during or after their procedure. The cervix was wiped clean of mucus and the probe applied to the cervix for two to three minutes or until the freezing zone extended one-eighth (1/8) inch to one-fourth (1/4) inch beyond the lesion to be treated. The probe temperature was −50 C to −60 C with Freon as the coolant. All patients were advised that they would experience a "watery discharge" the first few days and to avoid sexual relations for the first seven to 10 days. All patients were followed for at least three months after treatment.

Results

The patient's ages range from 18 to 70 years of age with an average age of 25.4 years. Twenty per cent of the patients were eight to 10 weeks postpartum and 60% of the patients were on birth control pills at the time of the cryosurgery. There were no major complications and the procedure was well tolerated by all patients. Approximately 10% of all patients noted a mild cramping sensation in the lower abdomen, but none requested discontinuance of the procedure.

As expected, the most frequent side effect was a "watery discharge" during the first few days. Because the women were fore-warned and advised to use a tampon, none of the patients was unduly disturbed about this drainage. Most patients were pleasantly surprised that the procedure was painless and especially happy to be treated as an outpatient without the usual expense of hospitalization and the hazards and worry of the operating room and anesthesia.

There were no abnormal Papanicolaou smears following cryosurgery, no cases of cervical stenosis, no changes in menses, nor any cases of dysmenorrhea or infertility attributed to cryosurgery. Four patients received cryosurgery with their intrauterine devices in place without abnormal sequela. It also was obvious that cryosurgery was painless when compared to electrocauterization.

The patients most satisfied with their treatments were those who had tried various methods of treatment and yet continued to be bothered with an irritating malodorous vaginal discharge secondary to chronic cervicitis. Most patients showed improve-

* Chief Obstetric Service, Good Samaritan Hospital, Vincennes.

* Model 5092 Frigitronics, Incorporated.

ment in the appearance of their cervix. The most dramatic changes were seen in cervices that initially appeared hypertrophied, friable to the point of bleeding from the slightest trauma, or cystic with multiple nabothian cysts. In six to eight weeks 90% of these patients were cured and their cervices well epithelized. Five percent were markedly improved and five percent not improved. Three patients received two applications of cryosurgery.

Conclusions

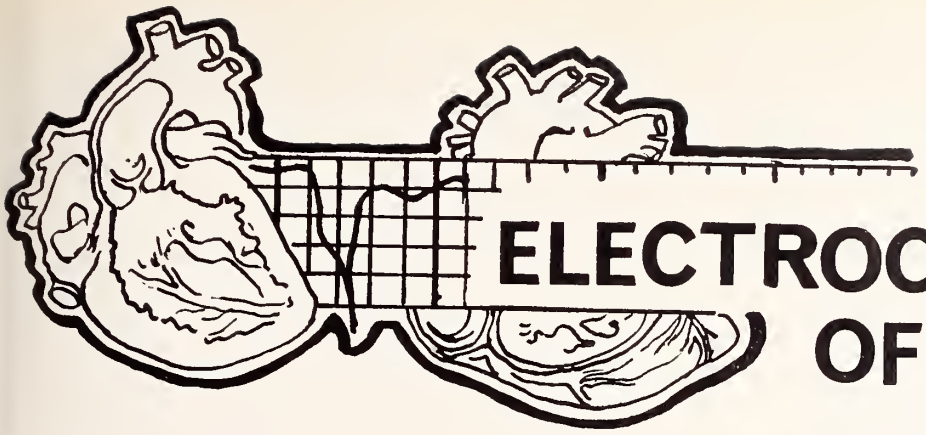
Treatment of chronic cervicitis is multiple and includes applications of antibiotic creams, suppositories and superficial cauterization. However, these methods are frequently ineffective and either deep electrocautery or conization and excision are needed to effect a cure. These last several methods require hospitalization, surgery with its complications of bleeding and cervical stenosis, and considerable loss of time and money to the patient.

The use of cryosurgery for the treatment of chronic cervicitis exceeds the above conventional methods of treating benign diseased tissue of the cervix. Cryosurgery is the treatment of choice for chronic cervicitis. It is faster, bloodless, simple, and healing is rapid without major complications.

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ELECTROCARDIOGRAM OF THE MONTH

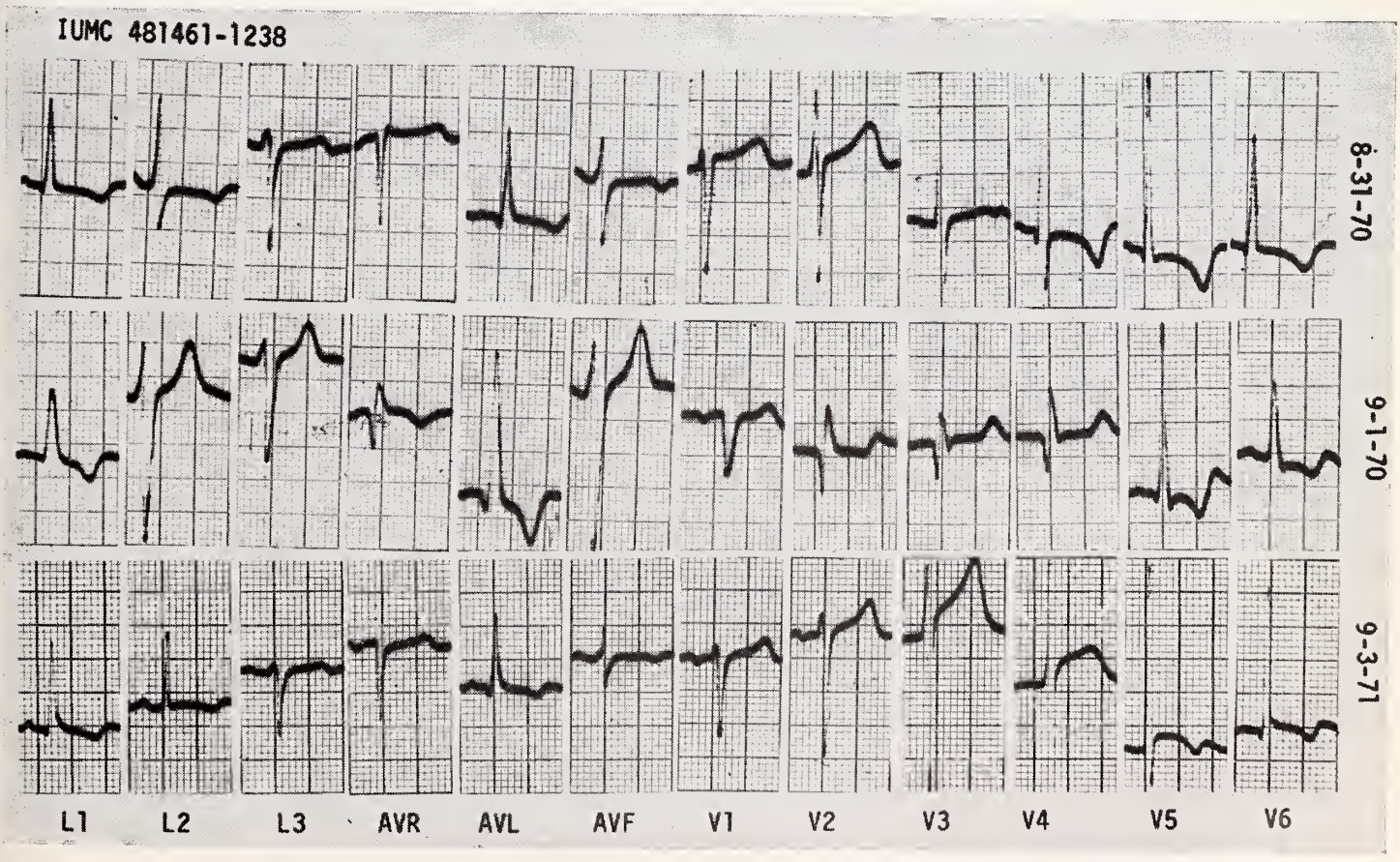
"Non-Coronary" Q Waves

CHARLES FISCH, M.D.

*Indianapolis**

A purely electrocardiographic (ECG) diagnosis of myocardial infarction without the characteristic Q wave is not possible. On the other hand there are numerous disorders which may give rise to a "non-coronary" Q wave. For this reason, even in the case of the highly diagnostic Q wave, the total clinical picture is essential for a definitive ECG diagnosis.

The accompanying figure is an example of "non-coronary" or "non-infarction" Q waves. The tracings were recorded in a 57-year old man with calcific aortic stenosis. The tracing recorded on 8-31-70 showed nonspecific ST-T changes with voltage criteria for left ventricular preponderance. On 8-31-70 the patient's aortic valve was replaced with a Starr-Edwards prosthesis. The ECG on 9-1-70 showed a prominent shift of the axis to the left and superiorly (left anterior "hemiblock"). There



* From the Krannert Institute of Cardiology, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis 46202.

was a loss of R waves in V_1, V_2 and V_3 with appearance of significant Q waves in V_1, V_2, V_3 and V_4 compatible with an anteroseptal infarction. These changes reverted to control by 9-3-71.

Such transient Q waves have been reported in other conditions, one of the explanations being that the myocardium becomes electrically inert, but the anatomical damage, if any, irreversible. ◄

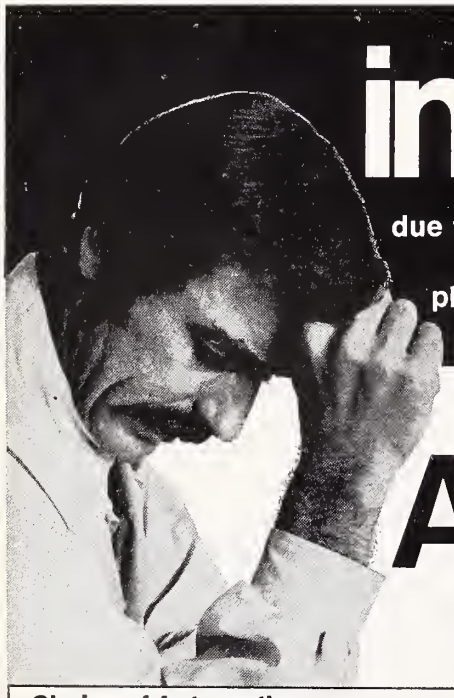
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Warnings: Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.

Hypercalcemia may occur, particularly in immobilized patients; use of Testosterone should be discontinued as soon as hypercalcemia is detected.

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FDA Urges Moratorium On Swordfish Use

THE consistent findings of high levels of methyl mercury in swordfish has prompted the FDA to urge the public to stop eating this one type of seafood.

In three months testing only 42 of 853 swordfish samples were found within the aceptable tolerance level (0.5 parts per million). Most of the samples are not just over the line. The average finding is twice the acceptable amount. More than eight percent of the samples were three times the acceptable level.

The FDA ruling came after the data had been considered by a panel of experts who were unable to suggest any basis on which swordfish consumption might be continued without a possible health hazard.

Appeal has been made directly to the public because the mercury contamination has been found so nearly universally in swordfish from all sources and because the multiple small sources of the product make it almost impossible to test each batch.

Canada, which is a major exporter of swordfish to the U.S., has suspended all export of this one fish.

The FDA continues to search for preventive and control measures but, in the meantime, is depending on the unusual public appeal for discontinuance of a dangerous food.

What's to Debate?

THE Indiana resolution on the subject of preserving the anti-substitution laws on prescription drugs was received favorably by the AMA House of Delegates in June. The resolution passed without difficulty. Leaders of the American Pharmaceutical Association, who are conducting a vigorous campaign to rescind all anti-substitution laws and regulations, objected to the AMA action on the basis that it did not debate the issue.

J. Leo McMahon, Associate Professor of Pharmacy Administration at the University of Missouri and Editor of *Action in Pharmacy* comments on this action in the September 1971 issue of *Action*, as follows:

"A recent editorial in the AMA Journal brought into focus the medical profession's reaction to the APhA's campaign to eliminate the anti-substitution laws. Where APhA leaders have been telling their constituents that the AMA was not giving the proper amount of thought to this issue—passing resolutions with little or no debate, etc.—it now appears the reason the AMA is not debating the issue is that they don't think there is anything to debate!

"The reaction of the AMA is not surprising. The physician considers it his prerogative to diagnose and prescribe and when he says prescribe he means he will determine the exact medicine the patient is to have. APhA leaders have contended that he should prescribe generically and the pharmacist should choose the brand. Obviously, medicine doesn't buy this argument."

Guest Editorials . . .

Ostomy Association Helpful to Hoosiers

THE United Ostomy Association presently has affiliated groups in

Fort Wayne, South Bend, LaPorte and Indianapolis and new groups are being formed in Muncie, Lafayette, Terre Haute, Bloomington, Evansville and Columbus.

The aims and purposes of these groups are to compile, publish and disseminate information for the better rehabilitation of persons who have lost the normal function of bowel or bladder necessitating colostomy, ileostomy, ileal bladder or ureterostomy surgery: to encourage and maintain an exchange of ideas and methods for the promotion of the rehabilitation of these persons; to promote and assist with research concerning the management of ostomies and the prosthetic equipment and appliances by assisting and cooperating with qualified persons in the pursuance of such research and study; to cooperate with other organizations dedicated, in whole or in part, to similar objectives in pursuit of the common purposes of the several organizations; to sponsor exhibits at leading medical and public meetings; to disseminate information for public education as to the nature of ostomy, thereby eliminating job and insurance discrimination.

All of the foregoing aims and purposes are directed to the complete rehabilitation of ostomy patients everywhere. Our ultimate goal is to help return every ostomy patient to a well-adjusted, normal and productive life.

The first ostomy group was formed in 1949 for the purpose of mutual aid, moral support and exchange of information. This idea spread to other cities throughout the world and continues today. In 1962 the United Ostomy Association was formed by an alliance of 28 such local groups. At present, over 120 groups comprise the UOA which is a non-profit service and educational agency. The officers and board of directors are elected from among the local component groups. The World Work Committee of UOA was recently established to promote international cooperation among National Ostomy Associations and to ultimately provide a World Ostomy Association.

The local organizations will send a member to visit with a new or prospective ostomate who is either hospitalized or in his home and who needs encouragement or assistance in the management of his ostomy. Visitation Committee members make these calls only upon the request of the patient's doctor. A member will be available to the patient for friendly visiting, reassurance and help with ostomy care and appliances during and after hospitalization.

An educational newsletter is published and contains articles of inspiration and information helpful to all ostomates, their families and friends. Qualified members conduct classes on ostomy care for student nurses, staff nurses and doctors upon request. Members are given an opportunity to help others and, in doing so, to help themselves. They are encouraged to resume their ordinary former activities in the home and in the community and to enter into the activities of their local ostomy groups.

Persons with an ostomy can benefit greatly from free exchange of knowledge and ideas made possible by local meetings. They meet and learn of approved ostomy care from well-known authorities and physicians who are invited to speak at meetings. They exchange helpful hints, they see and learn about various appliances and equipment available and obtain reading materials on ostomy care gathered from other groups around the world.

The *Ostomy Quarterly* is the official UOA publication with a current circulation of 14,000. This paramedical journal contains personal experiences of ostomates, articles by top medical and nursing specialists, articles on all aspects of ostomies, a complete listing of all local groups, a listing of local distributors of ostomy products and advertisements by manufacturers of ostomy products. Other publications include booklets describing the various types of ostomies and their management.

National conferences are held annually and are well attended by members, specialists in the medical and nursing professions, enterostomal therapists, suppliers and manufacturers. Most of the eleven UOA regions conduct seminars annually or as needed.

Further information can be obtained by contacting the United Ostomy Association, Inc., 1111 Wilshire Boulevard, Los Angeles 90017, telephone 213-481-2811; or their regional representative, E. J. Ward, 110 South Second St., Zionsville, 46077, telephone 317-873-3175.—**E. J. Ward.**

Pornography and Mental Health

ONE startling finding of *The Report of the Commission on Obscenity and Pornography* is that the effect of viewing sexually arousing material by both adolescents and adults was not only harmless, but a large percentage of viewers studied actually experienced beneficial effects. Also, contrary to popular belief, continued daily viewing of erotic material does not lead to increased interest in sexual matters, but instead results in satiation of sexual interest for as long as two months. Even more surprising, research findings showed that *less* explicit sexual material generates more arousal than more explicit depictions of sexuality, and that a person's own imagination in regard to material deleted from a book or movie can be far more sexually stimulating than if the gross details are left in.

My interest was aroused in the subject by being asked to be an expert witness in a court test regarding the alleged obscenity of a movie being

shown at a local theatre. In researching the subject I found very little in the literature of a scientifically valid nature. Even Kinsey's books, as excellent as they were when published over twenty years ago, seemed too superficial and not based upon solid research methods. Besides, social changes have been so dramatic in the past two decades that new, more relevant research information was needed in order to be an effective and objective witness. Then I recalled the Commission's report which was published in September, 1970. There, in that excellent comprehensive report, in the section headed "Effects Panel Report," was a wealth of new, well-documented, authoritative research findings and conclusions, which more than adequately filled my needs.

The major legal question revolved around what is meant by obscene. This is immediately narrowed down to what is meant by sexually obscene, since there are other types of obscenity such as political, religious, scatological, and sado-masochistic. The United States Supreme Court defined obscenity in the following way:

> Three elements must coalesce: it must be established that (a) the dominant theme of the material taken as a whole appeals to a prurient interest in sex; (b) the material is patently offensive because it affronts contemporary community standards relating to the description of representation of sexual matters; and (c) the material is utterly without redeeming social value.

Some justices thought that "national community standards" should be used and others thought that local or state standards should be the guide. At any rate, in order to be obscene, material must be offensive to a preponderance of the members of the community; otherwise, it would be difficult to assert that a community had any single standard.

Part (c) of the definition of obscenity seemed to offer the best area in which to exercise objective expert opinion, since "social value" of the effects of viewing erotic material had been well researched by the Effects Panel of the Commission. Even though hard core pornographic movies are both erotic and offensive, according to the findings and opinions of the Commission they are not "utterly without redeeming social value." The Commission found that persons who viewed such material seldom grossly modified their basic pattern of sexual behavior, be it normal or abnormal; but rather such viewers became more tolerant of the sexual behavior of other persons. Also, the satiation effect mentioned above contradicts the common misconception that habitual viewers of pornography might become "sex fiends."

In this writer's opinion, the viewing of sexual movies by married couples can be of definite clinical educational value. Prudish viewers are partially desensitized by seeing such films, which in turn leads to better adjustment in sexually troubled marriages. The importance of gaining knowledge about sex foreplay as depicted in some hard core movies can be of considerable value in those troubled marriages in which the wife complains that the husband mechanically gratifies himself without a loving consideration of her sexual needs. The mutual acquisition of such foreplay techniques leads to a healthier and happier marriage. Also the added knowledge of variations in actual intercourse adds zest and diminishes boredom throughout the many years of marriage. This is an important point since poor sexual adjustment is one of the major complaints of at least fifty percent of the emotionally disturbed couples seeking marital psychiatric help. Pornographic movies, therefore, crude as they are, fulfill a need until higher calibre educational films are produced for adult public viewing.

Two of the eighteen-member commission, Dr. Morris A. Lipton and Dr. Edward D. Greenwood, are psychiatrists. I had the privilege of working with Dr. Greenwood, who is head of the children's section of the Menninger Clinic, and I can vouch for his high integrity and dedication to everything he does. Some of the comments of these two men, who made a joint statement as part of the Commission's report, seem particularly interesting and relevant.

Both of these men are quite familiar with the research methods utilized in the study. However, they wished that they had had longer than the two years allowed to work at the problems, and that research could have been extended to include children and juveniles. They recognized that growing children are empirically educated in sex matters in a willy-nilly fashion from many sources but mostly by their peer group, often in distorted ways. Nevertheless, research failed to uncover any evidence relating exposure to erotica as being contributory to juvenile delinquency, crime, or antisocial behavior. They also found no causal relationship or even significant correlation between adult exposure to erotica and immediate or delayed antisocial behavior. Their objective stating of their findings did not imply that they approved of hard core pornography, since they said, "It is vulgar, distasteful, dull, a waste of money, and rapidly boring." They found pornography "to be a nuisance rather than an evil." And quoting from a public opinion poll they said, "The American public apparently agrees. Very few citizens consider the control of pornography to be among the most important problems of the day." In fact, in that

poll only two per cent did consider it of major importance.

Instead of allowing our growing youngsters to haphazardly acquire a distorted sex education, Drs. Greenwood and Lipton thought that "Gradual and age-appropriate exposure to erotic stimuli may lead to the development of socially appropriate defense mechanisms like sublimation, repression, postponement and self-control." Since they felt that overexposure to sexuality, especially at puberty, might lead to hyperstimulation of already overstimulated youths (due to the omnipresent overt and covert sexuality in comic books, standard movies, and commercial ads), they voted for appropriate legislation forbidding the sale of sexually explicit material to youths.

A specific goal of the Commission in regard to pornography was to help diminish interest in the subject by the population at large. A more general end was to facilitate the development of healthy sexual attitudes based upon accurate information and sound moral values. The two psychiatrists thought:

> Changing values regarding marriage, divorce, contraception, abortion, and even the right to have unlimited chidren in the face of a pending population crisis would have much more to do with changing sexual values and attitudes than does exposure to pornography. To the moral absolutist such change is sinful, to the relativist it may not be personally desirable but appears to be an inevitable product of newly emerging social problems.

What then should we do about pornography? These doctors suggested, "For adults and especially children, age-appropriate sex education presented accurately and truthfully in an appropriate aesthetic and moral context should do far more to reduce interest in pornography than any restrictive legislation which might be initiated."—**Byron Kilgore, M.D. Reprinted from** *The Bulletin of the Fort Wayne Medical Society*, **July 1971.**

Sense and Nonsense about the Wage-Price Freeze

THERE are now making the rounds a number of labor-sponsored myths and half-truths about the wage-price freeze.

Prime among these myths is the charge that the freeze favors the businessman because profits, dividends and interest rates are not included.

First, there is a very simple practical reason why they are not frozen: Congress did not give the President authority to freeze these items.

Second, as most people can figure out for themselves, dividends depend on profits, profits depend on prices, and prices *are* frozen. Furthermore, as a percentage of the Gross National Product, profits are at their lowest point in 35 years.

Interest rates are a separate category. If interest rates were kept artificially low in the U.S. by law, billions of dollars would flow abroad in search of higher rates there.

This outward flow would worsen our already serious balance of payments deficit. In addition, it would tend to make money (loans) unobtainable in the U.S., at the official rate, thereby worsening the plight of the home-buyer and small businessman.

Now, what about the 10% job development tax credit and the 7% auto excise tax repeal?

Those who oppose these actions insist that the proper way to stimulate the economy is to get more money (purchasing power) into the hands of the consumer, particularly the low-income consumer. But one of the problems with the present sluggish economy is that consumers are not spending the money they already have. Personal saving is running at a very high rate—above 8%.

Faced with this evidence, the President chose to try to stimulate business, to make its products more attractive to the consumer and to create more jobs. The creation of jobs, in turn, should increase consumer confidence in the economy and pry loose some of those savings.

The tax credit should also increase modernization of plant and equipment, which U.S. industry sorely needs to become competitive again with more modern, better-equipped rivals abroad.

All of which leads to the conclusion that it is in the best interest of all Americans to cooperate with the temporary 90-day freeze.—**Arch N. Booth, Executive Vice President, Chamber of Commerce of the United States.**

"Never on Weekends"

"NEVER on weekends" might be a motto worth observing, according to The Travelers Insurance Companies highway fact book entitled "Voice Behind The Wheel." The reason is simple. Nearly half the auto deaths and injuries occurred on weekends in 1970.

During 1970, 55,200 people lost their lives in traffic accidents and another 5,100,000 were injured, according to the booklet. Even though these figures are tragic, the number of those killed on our highways decreased by 1,300 from 1969.

Although there are many reasons why so many people are killed or injured on our highways every year, the fact that most deaths and injuries occur on weekends, and on weekdays between 6 p.m. and 6 a.m. suggests again that alcohol may be a serious contributor to the overall problem.

Another reason for the high rate of accidents during night time hours

is the tired driver. Remember that last long trip you took, trying to cover maximum distance in minimum time? Did you or did you not get sleepy? How many times did you shake your head before pulling in for a coffee or quick nap?

Excessive speeds accounted for 17,700 deaths. Perhaps some limits are not realistic, given modern highways and today's automobiles. But the fact is that we must become a slower population, not faster, if we are to cut down on our injuries and fatalities.—**The Travelers Insurance Companies, Hartford, Conn. 06115.**

Editorial Notes...

J. Enoch Powell, chief of the British National Health Service from 1960 to 1963, addressed the annual meeting of the AAPS in Clayton, Mo., a suburb of St. Louis, on October 8. He is regarded as one of the world's leading authorities on politically controlled medicine. After three years of trying to make the British plan work, he now admits it is an inherent failure. His may be one of the most important speeches ever made to an American medical audience.

The National Association of Boards of Pharmacy has resolved to "urge that the antisubstitution laws in the various states be retained and be effectively enforced by the various boards of pharmacy, in the interest of the protection of the public health and welfare of the citizens of their respective jurisdictions."

The Zenith Radio Corporation research group has developed an acoustic microscope which employs ultrasound and laser light scanner. The specimen to be investigated is immersed in water and a high-frequency sound wave is sent through it. When the sound wave strikes a plastic mirror the minute ripple pattern thus caused is scanned by a laser beam and converted to an electrical signal which produces an acoustic hologram or a magnified picture of the sound field on a television monitor. It is especially applicable to the study of cell tissues.

The Alexian Brothers Medical Center, Elk Grove Village, Ill. has installed a computerized medical history-taking system. It consists of a typewriter-like console with a keyboard and a small television-type screen upon which questions appear. The patient answers questions by touching one of four response keys or, in a few cases, by typing his answers on the keyboard. Some "yes" answers trigger a supplementary list of questions for patients who are not involved in case of a "no" answer. The machine produces a highly legible print-out.

The University of Florida reports the first scientfic testing of sleep learning. Investigators demonstrated that learning occurred during deep sleep as well as during the lighter stages and that the ability to learn improved with training. The process includes a preliminary tape which is played while the subject is awake—to condition the mind for the learning tape which is played later. The level of learning varied between 10% and 30%.

Standards have been revised to allow for greater curriculum flexibility in the training of medical assistants. The American Association of Medical Assistants has developed a basic one-year curriculum and provided for medical specialty courses within the existing two-year program. The types of schools which may be approved for medical assistant training, provided the clinical facilities are available, have been expanded.

"We note with considerable regret that the APhA has taken their case for the repeal of anti-substitution laws to consumerists, labor and political leaders. It may result in winning a battle, but we feel certain it will end in losing a war. This divorces pharmacy from the health team very effectively." J. Leo McMahon, assoc. prof. of pharmacy administration, University of Missouri, in the *Central Pharmaceutical Journal.*

Drs. McGrail and Oldfield of Toronto Medical School have described a method of creating an artificial larynx at the same time as laryngectomy. A pedicle of skin from the chest is used to form a tube which connects with the trachea. A special breathing tube inserted there allows air into the windpipe on inhaling and directs air through the new voice box on exhaling. Patients are able to talk within three to four weeks. ◀

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January 5, 1972—Indianapolis

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Director: Dr. Morris Green, Chairman and Professor of Pediatrics.

Refresher Course in Family Practice

(*American Board of Family Practice Oriented*)
January 11-13, 1972—Indianapolis

Designed to prepare the physician for the American Board of Family Practice examination, this three-day course will review all areas of Family Practice. Also, participants will gain experience with the specific testing modalities used in the Board Examination. The course will be patterned after suggestions made by the American Board of Family Practice and the American Academy of Family Practice.

Director: Dr. A. Alan Fischer, Associate Professor and Director of Family Practice Program.

Evaluation and Management of Coronary Artery Disease

January 19, 1972—Indianapolis

Continuing advances in diagnostic technics and therapy of coronary artery disease demand ongoing education in the management of this disease entity. The course will emphasize the evaluation of functional reserve as the approach to the diagnosis of clinical coronary artery disease. Topics covered will include the central role of the patient's history, the application of the resting and stress electrocardiogram, the use of cinearteriography to evaluate coronary blood flow, and recent advances in surgical management. The course will include ample opportunity for discussion among participants and faculty.

Director: Dr. Suzanne B. Knoebel, Associate Professor of Medicine.

Co-directors: Dr. Paul L. McHenry, Assistant Professor of Medicine.

Dr. John F. Phillips, Associate Professor of Medicine.

Sex Education — A Family Affair

January 26, 1972—Community Hospital, Indianapolis

This course will cover various prototypes of sex education in elementary and secondary schools, with the Pike Township program a classic example. Discussants will provide a critique of these prototypes and hopefully, in debate and forum, a critique of the basic concept of sex education for children in our schools. Also, one session will center on identifying the sources of information that children use in acquiring their knowledge of sex.

The course format will include audio-visual taped interviews as well as lectures, panel discussions, and question/answer periods.

Director: Dr. John I. Nurnberger, Director of the Institute of Psychiatric Research; Chairman and Professor of Psychiatry.

Genetics for the Clinician

February 9, 1972—Indianapolis

With the progressive identification and control of environmental factors that contribute to disease, genetically determined differences in host factors have become increasingly important causes of human mortality and morbidity. Genetics is relevant to all medical specialties, and in this course an attempt will be made to integrate recent advances with classical genetic principles in a framework that will be useful to the clinician. Specific topics that will be covered include cytogenetics, Mendelian inheritance, genetic heterogeneity, prenatal diagnosis and genetic counseling.

Director: Dr. Walter E. Nance, Professor of Medical Genetics and Professor of Medicine.

Psychiatric Emergencies

February 24, 1972—Evansville

The primary physician must frequently differentiate between psychiatric and medical emergencies. Faced with a psychiatric emergency, the physician must then decide upon a course of therapy. Staff members will discuss such cases as attempted suicide, the effects of sudden death in a family, and the effect of civil or criminal arrest. Attention then turns to the management of less acute situations: terminal illness, "social disease," unplanned pregnancy (in or out of wedlock), adjustment to permanent hospitalization, and family acceptance of the malformed or retarded child.

Co-directors: Dr. Thomas Spain, Director of Medical Education, St. Mary's Hospital.

Dr. Jerome Rietman, Psychiatrist.

The University of Colorado School of Medicine has announced its postgraduate calendar for 1972, as follows:

Colorado Academy of General Practice—Annual Sunday Symposium
January 23, 1972

Eighteenth Annual General Practice Review
January 24-29
February 7-12 (Repeat of January session)

High Risk Infant Care
February 14-18 (Limited)

Fifth Annual Symposium on Surgery of the Hand
February 22-25

Diagnostic Ultrasound
March 13-15

Trauma
March 20-24

Clinical Dermatology for the Family Physician
April 27-29 (Limited)

Marriage and Family Relations
June 5-10 (Estes Park, Colo.)

Eighteenth Annual General Practice Review
June 12-17 (Estes Park)
(Repeat of January and February sessions)

For further information and detailed programs, write to: The Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East Ninth Ave., Denver, Colo. 80220.

FUTURE MEETINGS, SEMINARS, COURSES

Diabetes Symposium Scheduled at Chicago

All interested physicians are invited to attend the Fourteenth Annual Symposium on Diabetes Mellitus which will be conducted by the Diabetes Association of Greater Chicago at the Lake Tower Inn, Lake Shore Drive and Ohio Street on Friday, November 19. The program will be devoted to "Pregnancy in the Diabetic" and "Neonate of the Diabetic Mother." Registration should be made in advance by writing Diabetes Association of Greater Chicago, 620 N. Michigan Ave., Chicago 60611. The fee for non-members is $10. Medical students and resident house staff members are free.

Set 13th National Conference On Medical Aspects of Sports

The 13th National Conference on the Medical Aspects of Sports, under the auspices of the AMA Committee on the Medical Aspects of Sports, will be held in New Orleans at the Jung Hotel on November 28, 1971. The conference is open to key non-medical athletic personnel as well as interested physicians. For full information write the AMA Committee at 535 N. Dearborn, Chicago 60610.

Schedule Seminar on Lenses October 31 at Indianapolis

The Certified Ophthalmic Dispensers Association of Indiana is sponsoring a Seminar on Press-on Lenses, made by the Optical Science Group, to be held at the Holiday Inn East, Road 67 and Road 100 in Indianapolis, on Sunday, October 31, 1971, from 1:00 to 4:00 p.m. OSG will have a representative to explain the application and uses of these lenses. Everyone concerned with eye care is invited. There will be a $5.00 registration fee for non-members.

Three AAGP Approved Programs Scheduled at U of Kentucky

Three programs which have been approved by the American Academy of General Practice have been announced by the University of Kentucky College of Medicine.

On November 19 and 20 "Psychiatry Put into Practice" will be given. The fee is $75 and Dr. Arnold M. Ludwig is program chairman.

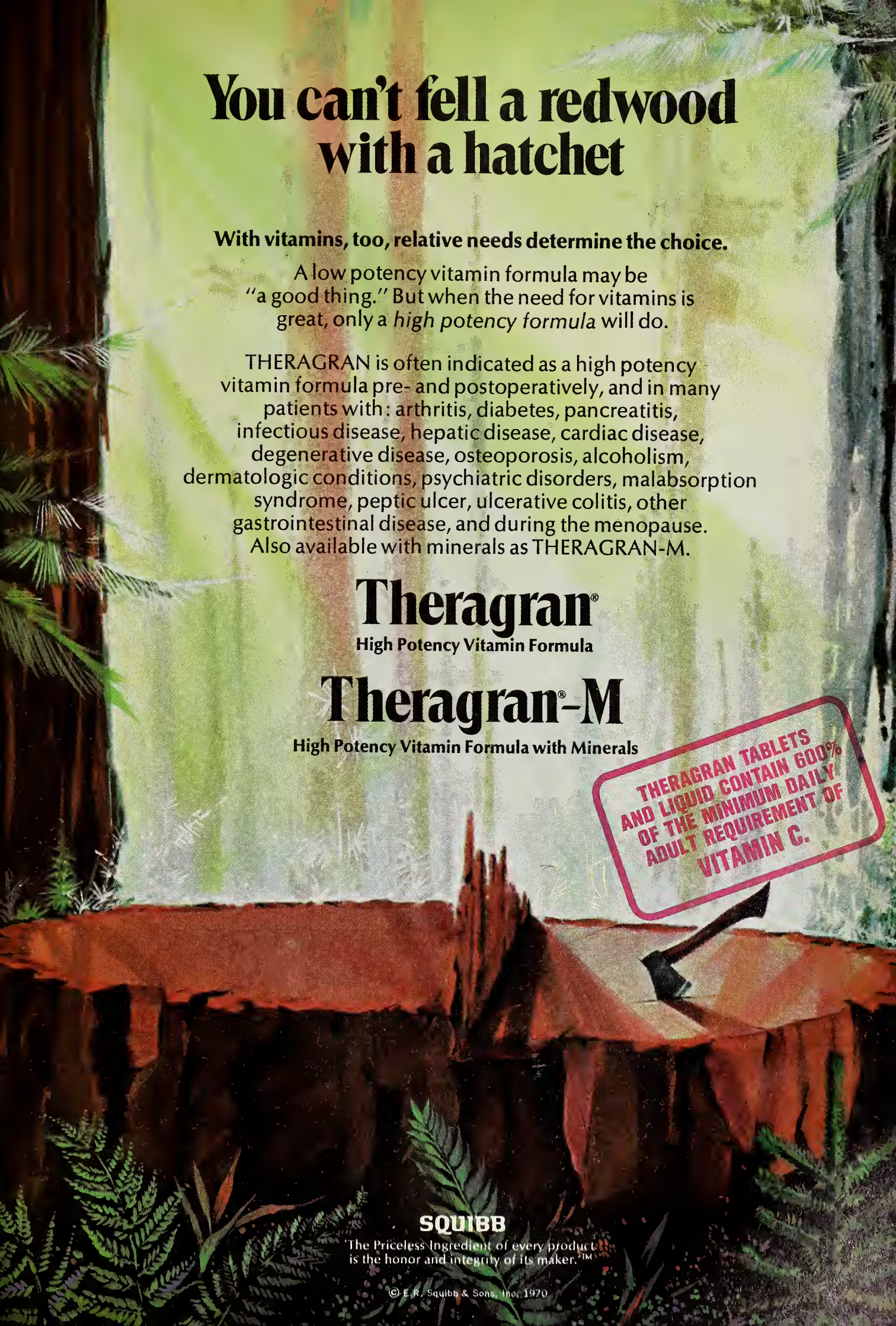
"The Practical Ophthalmology of Childhood," under the leadership of Dr. Jonathan Wirtschafter, is scheduled for December 17-18, and the fee is $50.

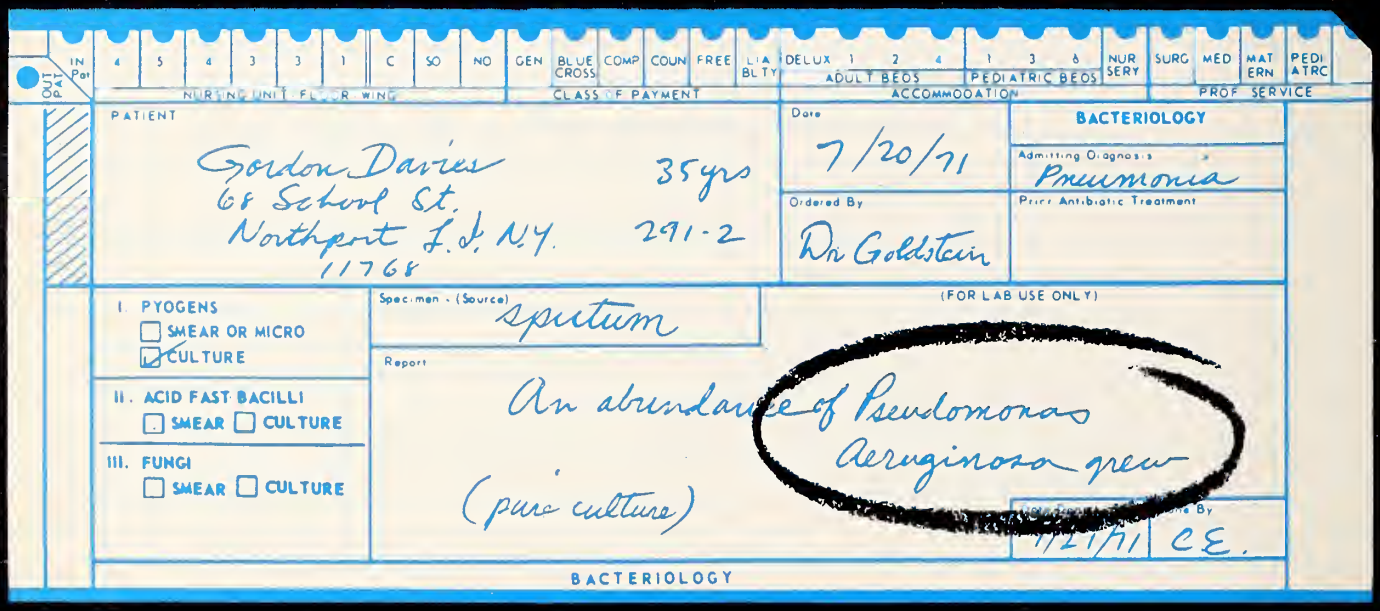
The week of February 6-12, 1972, is the period set for the Annual Family Medicine Review, and Dr. Frank R. Lemon is program chairman. In this case the fee is $175.

All programs will be at the University Medical Center, Lexington. Further information may be obtained from Frank R. Lemon, M.D., associate dean for continuing education, College of Medicine, University of Kentucky, Lexington, Ky. 40506.

Sex Education Workshop Set

A "Sex Education Workshop for Professionals" will be conducted by the Social Health Association of Indianapolis and Marion County in a weekend course 5 to 9 p.m. Dec. 3 and 8:30 a.m. to 6 p.m. Dec. 4; and on the four Monday nights in March, 1972, 6 p.m. to 9 p.m. Fee for the course is $40. Write Social Health Association, 615 N. Alabama St., Indianapolis 46204. ◄


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Although PYOPEN (disodium carbenicillin) is indicated primarily in Gram-negative infections, its activity against Gram-positive organisms should be kept in mind when both Gram-positive and Gram-negative organisms are isolated (see Actions). **Note:** During therapy, sensitivity testing should be repeated frequently to detect the possible emergence of resistant organisms. **Actions:** Organisms found to be susceptible *in vitro* include: Gram-Negative Organisms-*Ps. aeruginosa, Proteus mirabilis, Pr. morganii, Pr. rettgeri, Pr. vulgaris, E. coli, Enterobacter* species, *Salmonella* species, *Hemophilus influenzae,* and *Neisseria* species. Gram-Positive Organisms-*Staphylococcus aureus* (nonpenicillinase-producing), *Staph. albus, Diplococcus pneumoniae,* Beta-hemolytic streptococci, and *Streptococcus faecalis.* Some newly emerging pathogenic strains of *Herellea, Mima, Citrobacter,* and *Serratia* have also shown *in vitro* susceptibility. Not stable in the presence of penicillinase. *Klebsiella* species are resistant. Some strains of *Pseudomonas* have developed resistance fairly rapidly. **Contraindications:** Known penicillin allergy. **Warnings:** Serious and occasional fatal hypersensitivity (anaphylactic) reactions have been reported in patients on penicillin therapy. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens. There have been reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, appropriate therapy should be instituted and discontinuance of disodium carbenicillin therapy considered, unless the infection is life threatening and only amenable to disodium carbenicillin therapy. The usual agents (antihistamines, pressor amines, and corticosteroids) should be readily available. **Usage in Pregnancy:** Safety for use in pregnancy has not been established. **Precautions:** As with any other potent agent, it is advisable to check periodically for organ-system dysfunction, including renal, hepatic, and hematopoietic systems, during prolonged therapy. Emergence of resistant organisms, such as *Klebsiella* species and *Serratia* species, which may cause superinfection, should be kept in mind. Each gram contains 4.7 mEq sodium; in patients where sodium restriction is necessary, such as cardiac patients, periodic electrolyte determinations and monitoring of cardiac status should be made. Observe patients with renal impairment for bleeding manifestations and adhere strictly to dosage recommendations. If bleeding manifestations appear, discontinue antibiotic and institute appropriate therapy. As with any penicillin preparation, the possibility of an allergic response, including anaphylaxis, may occur, particularly in a hypersensitive individual. **Administration:** Intramuscular injections should be made well within the body of a relatively large muscle (not into the lower and mid-third of the upper arm), and aspiration is necessary to help avoid inadvertent injection into a blood vessel. May be given by either intravenous injection or intravenous infusion. After reconstitution with Sterile Water for Injection unused portions should be discarded after 24 hours if stored at room temperature, or after 72 hours if refrigerated. **Adverse Reactions:** *Hypersensitivity Reactions*—Skin rashes, eosinophilia, pruritus, urticaria, drug fever, and anaphylactic reactions. *Gastrointestinal Disturbances*—Nausea. *Hemic and Lymphatic Systems*—Hemolytic anemia, thrombocytopenia, leukopenia, neutropenia, in uremic patients receiving high doses (24 gm/day), hemorrhagic manifestations associated with abnormalities of coagulation tests, such as clotting and prothrombin time. *Hepatic and Renal Studies*—SGOT and SGPT elevations have been observed, particularly in children. To date, no clinical manifestations of renal disorders have been demonstrated. *Central Nervous System*—Convulsions or neuromuscular irritability could occur with excessively high serum levels. *Local Reactions*—Pain at the site of injection, sometimes accompanied by induration. Vein Irritation and Thrombophlebitis—particularly when undiluted solution is injected directly into the vein. **How Supplied:** Available in 1 Gm. and 5 Gm. vials.
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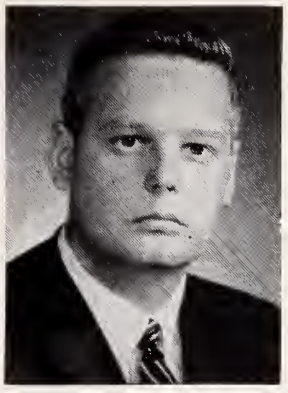
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TAX TIPS



by LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

PRESIDENT Nixon's executive order concerning the stabilization of prices, rents, wages and salaries was based upon the Economic Stabilization Act of 1970. This Act authorizes the President to issue such orders and regulations as he may deem appropriate to stabilize such items at levels not less than those prevailing on May 25, 1970. The major points of the order are as follows.

1. Prices, rents, wages and salaries are stabilized for a period of 90 days from August 16, 1971.
2. The stabilization levels are not to be greater than the highest of those pertaining to a substantial volume of actual transactions by each individual, business, firm or other entity during the 30-day period ending August 14, 1971, for like or similar commodities or services.
3. No person may charge, assess or receive (directly or indirectly) in *any transaction* prices or rents which are higher than those permitted by the order, nor may any person pay in *any transaction* wages or salaries which are higher than those permitted by the order, whether by retroactive increase or otherwise.
4. Each person who sells or provides commodities or services must maintain for *public inspection* a record of the highest prices or rents charged for similar commodities or services during the 30-day period ending August 14, 1971.
5. The foregoing points do not apply to the prices charged for raw agricultural products.
6. Whoever violates the order may be fined up to $5,000 for each violation.

By the time you read these comments the order will have been in effect for approximately two-thirds of its life. You are bound to have read several reports as to the effects of the order on this country. Also, by the time you read this President Nixon probably will have proposed a second type of governmental control. In anticipation of such a second control, many businesses are attempting to establish as high a base level as possible. Indeed, so many law firms throughout the country are being employed to argue cases concerning the first freeze that I think that President Nixon is going to find it difficult to hold down an abnormal increase in prices if a second control is not imposed.

You seldom have the opportunity to voice your opinion in advance as to a specific domestic policy that is as significant as the above order and as to whether the President or Congress should have the power to issue and enforce such orders. Take the time to send your opinion to the President. If you have additional thoughts, then add them—but at least take the time to comment.

President Richard M. Nixon
The White House
Washington, D.C.

I .... favor .... do not favor continued (for a reasonable period of time) governmental intervention concerning stabilization of prices, rents, wages and salaries.

(Signature)

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(fluoxymesterone, Upjohn)

Orally active androgen about 5 times as potent in anabolic and androgenic activity as methyltestosterone. Halotestin (fluoxymesterone) induces significant retention of calcium and potassium, but retention of sodium not marked. Doses below 20 mg. daily have little effect in producing creatinuria.

Indications *Male:* Replacement therapy in testicular hormone deficiency states. Prevents atrophy of the accessory male sex organs following castration for as long as therapy is continued. Impotence and male climacteric symptoms when due to androgen deficiency. Primary eunuchoidism and eunuchism. Delayed puberty when established as not a simple familial trait. Indicated for those symptoms of panhypopituitarism related to hypogonadism, however, appropriate adrenal cortical and thyroid hormone replacement therapy remain of primary importance. *Female:* Palliation of androgen-responsive, advanced, inoperable breast cancer in women between 1 and 5 years postmenopausal or women in whom castration has shown the tumor to be hormone dependent. Prevention of postpartum breast manifestations of pain and engorgement; there is no satisfactory evidence that this drug prevents or suppresses lactation per se. In osteoporosis androgens may be of adjunctive value to adequate considerations of diet, calcium balance, physiotherapy and general health promoting measures. *Males and Females:* In the treatment of protein depletion states which occur in geriatric patients, in debilitation states, in chronic corticoid therapy, resistant fractures; cryptorchidism; creating a positive nitrogen balance, tissue repair and other anabolic effects. Androgenic steroids may produce a response in aplastic anemias, myelofibrosis, myelosclerosis, agnogenic myeloid metaplasia and hypoplastic anemias due to malignancy or myelotoxic drugs. Androgens are not of value in other anemias.

Contraindications Pregnancy (may virilize female fetus), mammary carcinoma in the male, prostatic carcinoma, severe liver disease, severe cardiorenal disease and severe persistent hypercalcemia.

Precautions Employ with caution in young boys to avoid precocious sexual development and premature epiphyseal closure. Androgens tend to promote retention of sodium and water, therefore, watch for edema—particularly in the elderly. Incidence and severity of edema have been minimal and have been associated only with high doses used for palliation of breast cancer. Hypercalcemia may occur, particularly in patients with metastatic breast carcinoma; if this occurs the drug should be discontinued. Changes in liver function tests, such as increased BSP retention and SGOT levels, can occur during therapy. Jaundice has been rarely reported. If liver function tests are altered, discontinue medication or reduce dose. Priapism is indicative of excessive dosage and is indication for temporary withdrawal of drug. When treating protein depletion states or osteoporosis, an adequate diet should be provided and prolonged immobilization avoided whenever possible. When treating aplastic or hypoplastic anemias, androgen therapy should not replace other measure such as transfusion, correction of iron deficiency, antibacterial therapy, and the use of corticosteroids.

Adverse reactions Nausea, dyspepsia, menstrual irregularities, hepatic dysfunction, priapism, edema, precocious sexual development, and premature epiphyseal closure in young patients have been reported. *Male*—Prolonged administration or excessive dose may cause inhibition of testicular function with oligospermia and decreased ejaculation volume. *Female*—Large doses or prolonged administration may produce masculinization with signs such as hirsutism, deepening of the voice, enlargement of the clitoris, acne, and sometimes, increased libido.

Supplied *Tablets: 2 mg.*, scored—bottles of 100./ *5 mg.*, scored—bottles of 50./*10 mg.*, scored—bottles of 50.

For additional product information, see your Upjohn representative or consult the package circular.

Upjohn The Upjohn Company, Kalamazoo, Michigan

JA68-7627-R MED 8-5-5 (LQX)



ABSTRACTS, BOOK REVIEWS

A TEXTBOOK FOR MEDICAL ASSISTANTS

Lawton, M. M., and Foy, D. F.: C. V. Mosby Co., St. Louis, 1971.

This textbook meets a genuine need. Specifically, it is designed to provide needed background for personnel working in a physician's office. It does not apply to the broader category of "allied health personnel," "doctors' associates," "feldschers," "nurse-practitioners," and so on. In short, this is a book for the doctor's Girl Friday.

The book provides a treasure chest of information of great value to the medical assistant. It is divided into two parts—business practices and clinical practices—and properly so. Under business practices, the authors delve into such matters as public relations, general information about the types of doctors, the all-important social and professional amenities, hygiene, ethics, and jurisprudence, patients' records, the role of government in health, and the business aspects of conducting a medical office.

Under clinical practices, they present succinct summaries of anatomy and physiology, terminology, diagnosis, the various ramifications of medical and surgical office procedures, useful information on laboratory techniques and procedures, electrocardiography and x-ray, and handling emergencies. They finish with a good chapter on obtaining the job.

The book is well illustrated. Deserving of especial praise is the list of term definitions under the heading of "glossary" that precedes each chapter. The index is helpful. The book is securely bound and is obviously designed as a handbook. This reviewer can enthusiastically recommend it for all persons aspiring to be medical assistants.

W. D. SNIVELY, JR., M.D.
Evansville

PEDIATRIC ENDOCRINE PROBLEMS

M. M. Steiner, C. V. Mosby & Co., St. Louis, 1970; 406 pages; $29.50.

This volume represents an attempt at revitalizing textbooks for medical students, or reference books for practicing physicians, with a complete change of orientation.

The title suggest that the reader will be able to find in one volume: 1) a discussion of basic endocrine physiology in children, 2) discussion of specific endocrine problems organized by endocrine organ, 3) an inexpensive catalogue of diseases due to deficiencies or excesses of hormones, 4) an organized discussion of problems associated with hormone therapy, or 5) another endocrine textbook for medical students. Instead, the book is or-

Continued

ganized according to six chief complaints. The six chapters are based on excesses or deficiencies of height, weight and sexual development rather than an organ-by-organ arrangement (e.g., thyroid diseases). The principal approach is sound, but the final product is deficient in several easily remedied areas.

The first section, for example, deals with obesity in children. Many of the endocrine and non-endocrine causes of obesity are presented together with normal growth charts and calorie tables. Pertinent cases are presented in depth as examples of the usual problems. A number of rare and unusual entities is also included. Many of these are not specifically of endocrine etiology. Iatrogenic Cushing's disease is described, using many cases of various types. The appendix includes growth charts (redundant) with invaluable x-ray parameters for bone age, physical parameters for sexual maturity, and details of endocrine laboratory tests.

The chapter on short stature starts with a 16-page table of endocrine and non-endocrine problems associated with shortness. Following the discussion of endocrine diseases are a series of brief entries on genetic entities. Here is a possible advantage to the busy pediatrician or family practitioner; this is a rapidly scanned list of non-endocrine processes which probably should be included in the differential diagnosis of any child with extreme shortness. No general discussion of genetic disease mechanisms is given. However, there is little advantage to be gained by the average medical student, nurse or endocrinologist from this type of organization. The basics are lacking—summaries of endocrine and metabolic physiology—and might be located in one introductory chapter, although it is true that this information is present in various portions of the volume where it is related to specific endocrinopathies.

Despite the inconveniences imposed by the new format, this approach, with certain changes should be useful in the future.

JAY S. FLEISHMAN, M.D.
Muncie

HANDBOOK OF OBSTETRICS AND GYNECOLOGY

Ralph C. Benson, M.D., 4th ed., 1971, illustrated by Laurel V. Schaubert, Lange Medical Publications, Los Altos, Calif.; 753 pages plus index; $6.50.

This work has now attained fourth edition status and has also been available in Spanish and Portuguese, while Polish and Italian versions are soon to be available. Thus, it has stood the test of satisfaction to its users.

Dr. Benson is professor of obstetrics and gynecology at the University of Oregon Medical School Hospitals and Clinics, Portland.

No one, of course, sits down and reads such a book from cover to cover, but if he did in this case he should have a pretty good idea of what obstetrics-gynecology is all about. Used as it is intended, a handbook, one finds it well stocked with usable information, clinically oriented. This is well shown in the succinct but thorough essay on subjects such as dyspareunia, pelvic pain, marriage counseling, frigidity, backache and many others. In addition, the descriptive anatomy and embryology are well done.

Additions to this edition include suction surettage, indices of fetal gestational age, abnormal lactation, induction of ovulation, staging of ovarian cancer and irrigation of the uterus for diagnosis of endometrial carcinoma.

There are various tables and figures all through the book and numerous anatomical diagrams and illustrations, with only one of the latter showing an error (indicator lines from two different anatomical designations ending on the same pelvic diameter; Fig. 4-4).

Judicious advice is given throughout the book, so that it is not just a compendium of facts, tables of statistics, etc. A drawback is that it has become rather thick and heavy for pocket use, and an edition in Bible paper with slightly larger type would be a distinct improvement, even though more expensive.

A. W. CAVINS, M.D.
Terre Haute

THE HUMAN HEART, A GUIDE TO HEART DISEASE

Phibbs, B.: 2nd ed., C. V. Mosby, St. Louis, 1971; $5.75.

This book, a second edition, is designed particularly for nurses, aides and technologists working in coronary care units or involved in other aspects of the care of cardiac patients. Originally, the book was designed as a manual for patients. The simplicity and clarity of the second edition preserves its usefulness for that audience.

HELP FOR THE CONGENITALLY HANDICAPPED CHILD It wasn't so long aga that congenitally handicapped children were allowed to reach schaal age ar even later befare being fitted with a prasthesis. In recent years, experience has shawn that fitting at an earlier age praduces mare effective results—bath mentally as well as physically. HANGER provides individually designed prastheses to give aid to the cangenitally handicapped child. Children with "HANGER PROSTHESES" can live narmal lives. Using their HANGER appliances they exercise freely, ride bicycles, raller skate, play basketball, tennis, and engage in mast of the activities like other growing children. These activities enable the child to become self-reliant. Each HANGER prosthesis fallaws much the same design as those far the adult, but utilizes specially develaped campanents of appropriate size, thus providing a smaather transitian as the child graws into adulthaad. HANGER also provides devices and techniques far the initial fitting af infants and problem cases. Training af children in the use of their prasthesis is highly desirable, even though children present same prablems nat seen in adults. Since the attentian span af yaung children is short, extreme patience is required. Same handicaps make an ideal gait-pattern difficult if not virtually impassible ta achieve. It should be noted that camplete caaperatian of the parent is necessary regardless of the experience and ability af the therapist. (Often the parents pass an a sense af guilt that is campletely unfaunded as there are no knawn preventive methods ta cambat the problem of a cangenital handicap.)

Hanger PROSTHESES

1332 N. Illinois St., Indianapolis, Indiana 46202
312 E. McMillan St., Cincinnati, Ohio 45219
416 N. Main Street, Evansville, Indiana 47711

The book is well and interestingly written. The primary author is obviously well qualified to do such a book. He has four able and equally well-qualified contributors.

The book describes the physiology of the normal heart then delves into the principal cardiac disorders, including rheumatic fever, infectious heart disease, hypertensive heart disease, coronary artery disease and congenital heart malformations. An excellent chapter deals with the electrocardiogram. Treatment, both medical and surgical, is covered. The topic of what to do about a heart attack is particularly useful. It includes management in the wilderness far from any possible help.

The book has numerous excellent illustrations, including drawings, photographs and diagrams. It can be heartily recommended for its intended audience. Physicians not frequently involved in treating patients with heart disease would find the book an interesting and stimulating review.

W. D. SNIVELY, JR., M.D.
Evansville

G-6-PD (GLUCOSE-6-PHOSPHATE DEHYDROGENASE) DEFICIENCY

D. F. Keller, M.D., CRC Press, Cleveland, Ohio; 65 pages with numerous illustrations and a complete bibliography; 1971; $6.50.

This slim volume is a rewrite of an article that appeared originally in "CRC Critical Reviews in Clinical Laboratory Sciences." Dr. Keller deserves commendation for the excellent performance of a tedious and exacting task.

Erythrocyte anomalies such as thalassemia, both major and minor, sickling and many others have been known for a long time. Drug-induced hemolytic anemias have come into prominence, especially since the use of antimalarials in WWII and since. Table 4, on page 30 of this monograph, gives a column listing occupying almost an entire page! The crucial importance of G-6-PD deficiency in all these potentially lethal situations is in the process of being worked out and is the raison d'etre for the present opus.

The question of mosaicism is entered into simply and with crisp authority. The ethnic situations should be understood by doctors both inside and outside the army. The point of stress as causation of overt hemolysis cannot be over-emphasized. All in all, this exposition of the biochemistry and genetics of G-6-PD deficiency should be added to the lexicon of practicing physicians.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

HANDBOOK OF PSYCHIATRY

Solomon, P., and Patch, V.: 2nd ed., Lange Medical Publications, Los Altos, Calif., 1971; $7.50.

This handbook presents a condensed multiple-author approach to the high points of clinical psychiatry. Both the editors and the authors are eminently well qualified to produce such a book. Careful editing and coordination of the several chapters result in a unified text. As the editors point out, this is a *handbook* designed for quick consultation when psychiatric problems arise. The authors describe it as a "storehouse of information of current practical importance," an accurate characterization. It is certainly "small, compact, factual, and reasonably devoid of speculative or controversial data." Its strength lies in part in its brevity.

In addition to the conventional topics usually covered in psychiatric handbooks, excellent chapters reveal the relevance of this text to the current scene—"The Doctor-Patient Relationship"; "The Mind and the Brain"; "Psychiatric Epidemiology"; "Psychophysiologic Disorders"; "Chronic Alcoholism"; "Drug Dependence"; "Group Therapy"; and "Community Psychiatry."

The text is well written; excellent bibliographies follow each chapter. There is a minimum of tables, graphs and bar charts. The book is sturdily bound with plastic-paper covers. I can enthusiastically endorse it for the family physician, the internist, indeed, for all non-psychiatrists; it will probably serve them better than would one of the tomes on psychiatry.

W. D. SNIVELY, JR., M.D.
Evansville

Abstracts from Various Literature, Prepared by AMA

COFFEE-DRINKING AND CANCER OF LOWER URINARY TRACT

P. Cole (Harvard School of Public Health, Boston 02115)
Lancet 1:1335-1336 (June 26) 1971.

Interviews were conducted with a population-based series of patients with cancer of lower urinary tract and controls were drawn from the same population. An unanticipated finding is association of the disease with coffee-drinking. The relative risk for coffee drinkers, compared to non-drinkers is 1.24 among men and 2.58 ($P < 0.05$) among women. The association is strong in the sex-age groups in which the association of the disease with cigarette-smoking and occupation are not strong.

EFFECTS OF MARIHUANA ON THE SOLUTION OF ANAGRAMS, MEMORY AND APPETITE

E. L. Abel (Dept. of Psychology, Univ. of Toronto, Toronto)
Nature 231:260-261 (May 28) 1971.

Thirteen adults between the ages of 22 and 37 served as volunteer subjects. Before the experiment began, and at least 30 minutes before any subjects were given marihuana, each subject was given a plate of marshmallows. At the beginning of part A each subject was tested on the Taylor manifest anxiety scale. After the questionnaire had been administered, the subjects took part in an anagrams game. The subjects' task was to unscramble the letters in the shortest possible time. Part B followed immediately after the return of the marshmallows to each subject. Subjects were then asked to listen to a "newspaper report," which was in fact a copy of the Babcock memory test described by Rapaport. Subjects in the marihuana condition were then given two marihuana cigarettes to smoke. After its completion, subjects were asked to write out as much of the newspaper story as each could remember. There were no significant differences in the recall of items from the anagrams list in part A. In part B, however, subjects who had smoked marihuana recalled significantly fewer items

Continued

than did controls. Comparison of the error scores also indicates that not only do marihuana subjects remember less than controls, but what they do recall is likely to be less accurate. As for the effects of marihuana on hunger, it increased the subjects' desire for food.

ACID-STIMULATING PROPERTIES OF VARIOUS DAIRY PRODUCTS USED IN TREATMENT OF PEPTIC ULCER

R. Phimolsarnti et al. (Univ. of Minnesota, Minneapolis 55455) *Amer. Surg.* 37:253-255 (May) 1971.

Experiments showed that whole milk does not depress the acid output of Heidenhain pouch dogs as much as Sippy I diet does, despite the fact that they are both dairy products. Difference in acid production may be due to the different fat contents (12% fat vs. 4%). Ingested animal and vegetable fats may differ in acid production; however, it was demonstrated by Kotrba and Code that the addition of olive oil to meat had no significant effect on the acid secretion. A diet of cornflakes and butter causes less acid secretion than the standard and well established Sippy I diet itself. This suggests that cornflakes and butter could be added to the somewhat strict Sippy I "ulcer diet" schedule, both because of low acid-stimulating properties and because it offers a palatable substitute with a pleasing aroma.

MALIGNANCY DURING METHOTREXATE AND STEROID THERAPY FOR PSORIASIS

C. C. Harris (Univ. of California Hosp., Los Angeles 90024) *Arch. Derm.* 103:501-504 (May) 1971.

The concept of immunologic surveillance as a defense against cancer has been proved valid in experimental and clinical studies. A deficiency of the immune system increases the risk of malignancy, as exemplified by the increased tumor incidence found in patients with immunologic deficiency diseases and in immunosuppressed patients bearing renal transplants. A case report is presented of a 32-year-old man in whom carcinoma with metastases developed during oral methotrexate and steroid therapy for psoriasis. Immunosuppressive agents are being used increasingly in the therapy of nonfatal disorders and in the prevention of immune rejection of transplanted organs. The probability of increased risk of cancer and spread of metastases in these patients should be evaluated by prospective studies. ◄

Pre-Sate® (chlorphentermine hydrochloride)

Caution: Federal law prohibits dispensing without prescription.

Indications
Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (i.e. several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.

Contraindications
Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.

Warnings
When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.
Drug Dependence Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with the high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.
Usage In Pregnancy The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.
Usage In Children Not recommended for use in children under 12 years of age.

Precautions
In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorectic agent and a restrictive dietary regimen.

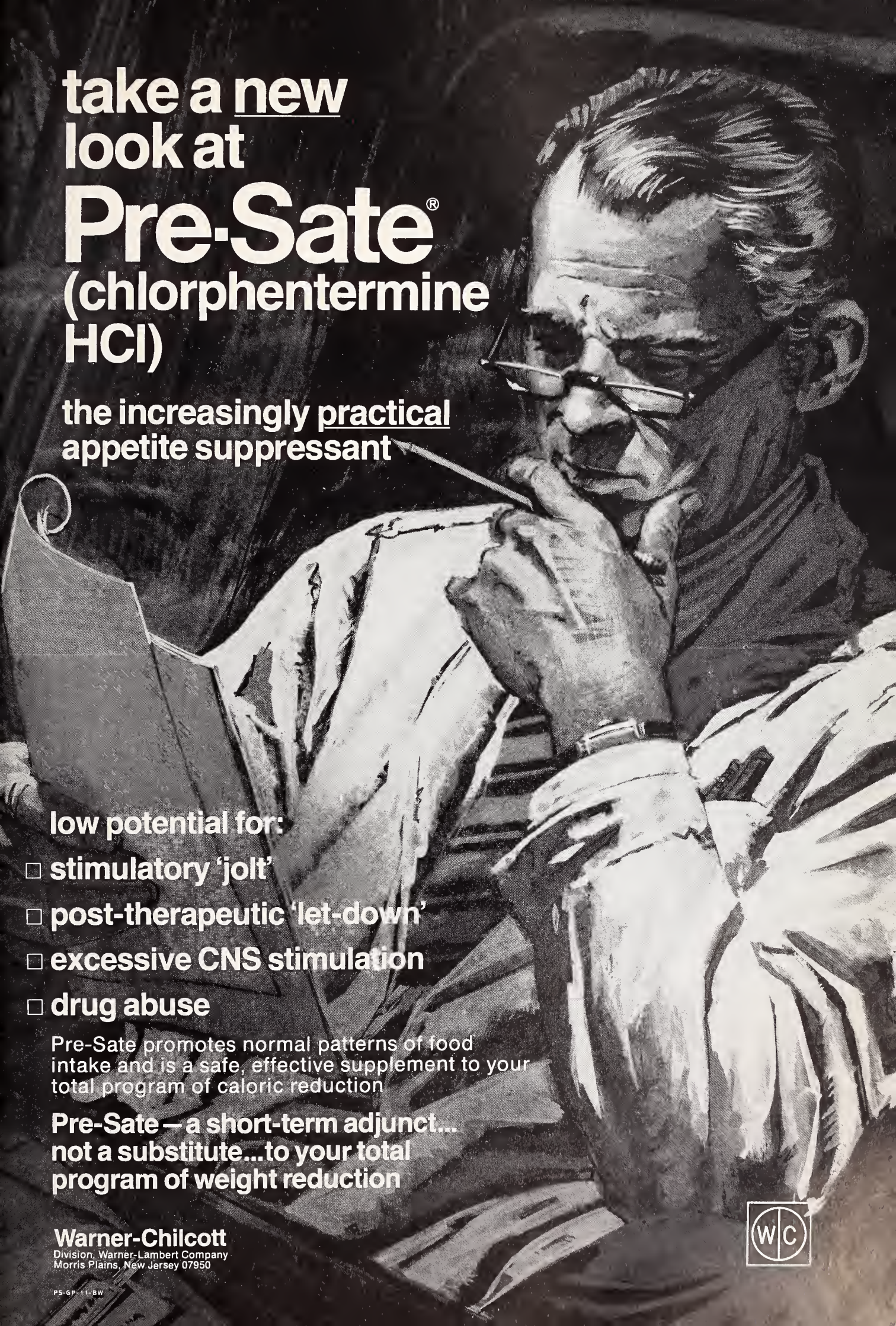
Adverse Reactions
Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.

Dosage and Administration
The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.

Overdosage
Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.
Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

How Supplied
Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.

Full information is available on request.


take a new look at
Pre-Sate®
(chlorphentermine HCl)
the increasingly practical appetite suppressant
low potential for:
□ stimulatory 'jolt'
□ post-therapeutic 'let-down'
□ excessive CNS stimulation
□ drug abuse
Pre-Sate promotes normal patterns of food intake and is a safe, effective supplement to your total program of caloric reduction
Pre-Sate—a short-term adjunct... not a substitute...to your total program of weight reduction
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Division, Warner-Lambert Company
Morris Plains, New Jersey 07950
PS-GP-11-BW
WC



Blue Shield Chairman Reports To ISMA House of Delegates

JOSEPH M. BLACK, M.D.

Seymour*

Fellow physicians:

THIS year Blue Shield in Indiana reaches a milestone—a quarter of a century of service.

People dedicated to helping other people has been the story of our first quarter century. People such as physicians, nurses and scientists—and people who joined together to underwrite the cost of needed health care. As medicine made tremendous advances during the past 25 years, these were applied to more and more people. And many thousands who might have died only a few years before were cured.

Indiana Blue Shield claims a major role—along with Indiana physicians—in ridding the citizens of the state of many of the uncertainties and much of the "red tape" of conventional insurance. At the outset of this Blue Shield program back in 1946 no one really knew how much popular appeal this program would generate.

To those venturesome subscribers of 25 years ago, the newly organized Blue Shield plan offered a list of benefits which seems extremely modest as measured against today's standards. As Blue Shield was blessed with other favorable circumstances, there developed what amounted to almost a race to meet the community's demand for protection against doctor bills and to keep benefits abreast of the public need and the advancement of medicine.

Indiana Blue Shield reacted with a sense of urgency to meet the needs of both the Indiana physicians and the community. Today, Blue Shield offers a comprehensive range of benefits and works cooperatively serving physicians throughout the state. Every day Indiana Blue Shield now pays Hoosier physicians considerably more than the $65,000 of starting capital advanced in 1946.

During our first 25 years, despite the problems of war and serious inflation, there has been no end to the growth of Indiana Blue Shield. Latest figures show that—including our government programs—we now serve more than 50% of Indiana residents. After each rate increase someone has suggested that it might be better to reduce benefits rather than raise the cost of protection. It is obvious to us that this would not only negate the original Blue Shield purpose, but would also amount to little more than postponing the day of reckoning. Thus far, the basic Blue Shield philosophy has held firm: Payment for medical services people need without cash restrictions limiting their access to proper health care.

As medical advances have increased physician capacities to save health and life, Blue Shield has correspondingly provided for these systematic gains in contracts to the majority of subscribers. For Indiana Blue Shield, size has meant greater capacity for public good. We are now the ninth largest of the 72 Blue Shield Plans.

Only 20 years ago there were no benefits covering psychiatric services, anesthesia or out-patient diagnostic x-ray and pathology services. During 1970, however, Blue Shield paid over $300,000 for psychiatric services; more than 3½ million dollars for anesthesia; and over $8 million for out-patient diagnostic x-ray and pathology services. Blue Shield also paid in excess of $5½ million in Medicare Supplement benefits during 1970. Total benefit dollars paid by Blue Shield during 1970 exceeded the total of 1950 by over $48 million.

Growth of Indiana Blue Shield was evidenced in both regular and government business during the past

* This report was made to the House of Delegates of the Indiana State Medical Association earlier this month by Doctor Black, who is Chairman of the Blue Shield board of directors.

year. Income from membership fees in 1970 reached a record total of $61,958,912, up 19% over the previous year's figure of $52,058,633. We returned 94½ cents of each membership dollar in the form of benefits for surgical and medical care.

A total of $58,551,150 was paid for members' surgical and medical care, a 22.5% increase over the previous year's figure of $47,788,939, and the biggest annual increase in our history.

Part B Medicare payments continued to be an important Blue Shield service during 1970. Claims approved increased to almost 630,000 last year from 593,000 in 1969.

Medicaid brought a huge new source of claims volume. Original estimates projected a weekly volume of 15,000 claims. But changed eligibility regulations brought an unforeseen avalanche of between 40,000 and 50,000 claims per week in February. Some systematic adjustments were made, and by July 1 we had succeeded in stabilizing the situation.

During the past year the Medicaid Division processed over 1,800,000 claims and paid out $13.3 million in benefits. Medicaid was responsible for more than tripling the claims processed in government programs, from 876,000 to over 3 million. Benefit dollars increased from $32.4 million to $46.7 million.

Claims Volume Doubled

The overall effect of Medicaid and other business claims increases raised the Blue Shield total claims volume from 2.2 million to 5.4 million. Dollar benefits did not increase as dramatically, primarily because 80% of the Medicaid claims were prescription drugs, which are low cost items. However, Blue Shield paid out $108 million in 1970, compared to $79 million in 1969.

Although entering the Medicaid program placed a great burden on the corporation, it has broadened our reputation as a community service organization in the health care field. Almost no corporation is called upon to absorb a year-to-year doubling of workload in the course of doing business. But, quietly and without fanfare, that is precisely what Blue Shield has done in the past year.

Indiana Blue Shield's Professional Relations staff continues to expand, providing greater service to physicians and their medical assistants by helping solve problems and furnishing information with regard to Blue Shield.

Eight persons who comprise the External Staff are a part of a total of 25 now in the department. Assisting the head of the staff are a field manager and six field representatives, two of whom cover the entire state, specializing in government control work, and four who service specific areas.

Professional Relations has recently concluded 134 two-hour workshops for doctor's assistants, and this fall will hold 24 dinner workshops for medical assistants.

The past year saw Professional Relations expand its program of liaison contacts to include pharmacists, dentists, durable goods dealers and ambulance providers.

The participating pharmacy network alone now numbers approximately 1,150 drug stores.

One of the most important developments in Professional Relations of the past year was the use of data processing capabilities to support and aid utilization review.

Although the review is strictly the responsibility of the medical profession, Indiana Blue Shield is now abe to assist peer review committees through its data processing availability. We are now able to furnish statistics relative to local patterns of practice for county medical societies, which make review and evaluation even more effective.

This computerized program of analysis links together Blue Shield and the medical profession and forms a responsible, workable solution to the rare instances of abuse and impropriety within the health care field.

One of the highlights of the past year was the annual Blue Shield Professional Relations Seminar at Indianapolis in April where more than 325 doctors and their wives were in attendance. Emphasis was on alternate methods of delivery of health care, with speakers from throughout the country outlining what was being done in their communities.

Doctor-Directors Retire

As a part of the seminar, two retiring Blue Shield Board members—Dr. F. W. McDowell of Muncie, and Dr. George W. Willison of Evansville—were honored for their long service.

This year the long-awaited dream of all Blue Shield and Blue Cross main office operations under one roof has been realized.

The corporations had been expanded into 11 different office locations in Indianapolis prior to merging into the new quarters. The move into the new 18-story Service Center at 120 West Market Street promises a new era of service, growth and efficiency. Use of the new facilities is expected to help Blue Shield greatly in its never-ending efforts to meet the financial needs of the more than two million Hoosiers we serve. I hope that when you are in the Indianapolis area you will stop by and give one of our staff members an opportunity to take you on a tour of our new Service Center.

As the second quarter century brings important new responsibilities, Blue Shield and the medical profession remain committed to a joint purpose of working together to see that quality health care is within the reach of the vast majority of the people in Indiana. ◄

WHEN TRAUMA RESULTS IN PAIN...



This photograph in no way implies an endorsement of Norgesic by Jerry Quarry

Norgesic . . . provides effective analgesia and relief of associated muscle spasm

Contraindications: Because of the mild anticholinergic effect of orphenadrine, Norgesic should not be used in patients with glaucoma, pyloric or duodenal obstruction, achalasia, prostatic hypertrophy or obstructions at the bladder neck. Norgesic is also contraindicated in patients with myasthenia gravis and in patients known to be sensitive to aspirin, phenacetin or caffeine.

Since mental confusion, anxiety and tremors have been reported in patients receiving orphenadrine and propoxyphene concurrently, it is recommended that Norgesic not be given in combination with propoxyphene (Darvon®).

Warnings: USE IN PREGNANCY. Since safety of the use of this preparation in pregnancy, during lactation, or in the child-bearing age has not been established, use of the drug in such patients requires that the potential benefits of the drug be weighed against its possible hazard to the mother and child.

USE IN CHILDREN: The safe and effective use of this drug in children has not been established; therefore, the physician must weigh the benefits against the potential hazards.

Precautions: It has been reported that prolonged or excessive use of phenacetin may result in nephrotoxicity. Caution, therefore, should be exercised when Norgesic is administered to patients with renal disorders. It should also be used with caution in patients with tachycardia.

Adverse Reactions: Side effects of Norgesic are those seen with APC or those usually associated with mild anticholinergic agents. These may include tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased intraocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently an elderly patient may experience some degree of confusion. Mild central excitation and occasional hallucinations may be observed. These mild side effects can usually be eliminated by reduction in dosage. One case of aplastic anemia associated with the use of Norgesic has been reported. No causal relationship has been established.

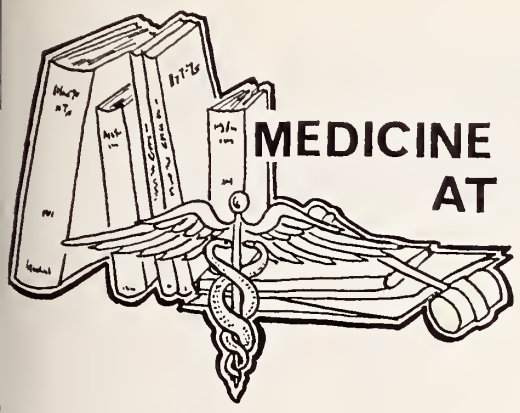
Dosage and Administration: Adults—1 to 2 tablets 3 to 4 times daily.

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MEDICINE AT LAW

Cooperation with Psychiatrists Required When Insanity Pleaded as Defense—Where an accused murderer relied on a defense of insanity, the privilege against self-incrimination was not violated by requiring cooperation with court-appointed psychiatrists, the highest court of Florida ruled.

A woman accused of murdering her husband entered a plea of not guilty by reason of insanity. The trial court appointed two psychiatrists to examine the woman for the purpose of determining her mental condition at the time of the crime.

At the hearing before the psychiatrists, the accused woman refused to answer questions regarding her mental status or medical history, invoking the constitutional privilege against self-incrimination. The trial court ordered the woman to cooperate with the psychiatrists, saying that if she did not do so her own evidence of insanity would be excluded from the trial.

The appellate court affirmed the ruling of the trial court, holding that the issue of insanity is separate from the issue of guilt. The accused woman invited inquiry into her mental condition when she pleaded not guilty by reason of insanity.

In upholding the opinion of the appellate court, the Supreme Court of Florida ruled that the privilege against self-incrimination did not extend to exclusion of evidence of an accused person's mental condition when such evidence was relevant and material, even when it was obtained by compulsion. The insanity plea raised separate issues from those raised by the guilty plea, the court further held, and different kinds of evidence might be introduced on the two issues. Examining psychiatrists should testify only regarding the sanity or insanity of the accused person and should not give information as to any facts regarding the crime unless the counsel for the accused person opened the inquiry to collateral issues.

According to the M'Naghten rule, if a person knows the nature of an act and knows that it is wrong, that person has sufficient mental capacity to be responsible for not controlling his action. Under criminal law, a person is presumed sane unless that presumption is overcome.—*Parkin v. State of Florida*, 238 So. 2d 817 (Fla.Sup.Ct., July 13, 1970; rehearing denied, Sept. 21, 1970); cert. denied, 91 S. Ct. 1189 (U.S. Sup.Ct., March 22, 1971). ◄

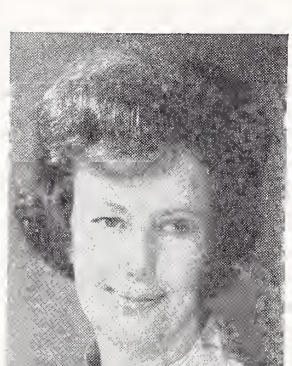
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The Woman's Auxiliary

REPORTS TO ISMA



There is a lot of activity in the political arena these days. It is up to each of us to be as well informed as possible and to act accordingly.

This month we have invited Mrs. G. Beach Gattman to be our guest writer. Mrs. Gattman (Ruth) is talented, conscientious and is the Auxiliary's legislative chairman. She has recently been oppointed to serve on the IMPAC-AMPAC board. You may have already heard from Ruth, as she has been busy getting in touch with all of you concerning support of IMPAC-AMPAC.

Lelia M. Chernish

"If, so to please the people, we offer what we ourselves disapprove, how can we afterwards defend our work?"—George Washington.

With the debate on national health insurance already begun, the above quotation becomes especially relevant to each of us in the field of legislation. Recognizing the fact that each County Legislation Chairman is just beginning to become informed herself on National Health Insurance, the following guidelines were mailed to each County Chairman during the summer. Perhaps they will give you a better idea of the importance the Auxiliary has placed on keeping our members legislatively informed.

"THE AMA HAS RECENTLY NAMED *LEGISLATION*—SPECIFICALLY NATIONAL HEALTH INSURANCE—IT'S NUMBER ONE PRIORITY.

"Accordingly, I am asking each of you to:

"1. Contact your County President NOW and ask her to set one meeting aside for a program on legislation;

"2. After you have obtained her approval, contact the Legislation Chairman of your County Medical Society or your County Medical Society Program Chairman and see if it would be possible to make this a joint meeting with the men;

"3. The ISMA has offered us its services in setting up programs on National Health Insurance. They have obtained from the AMA a slide-film presentation with sound on Medicredit. You may obtain this by writing to the ISMA. They will be happy to arrange a panel on National Health Insurance with a speaker from the AFL-CIO and one from the AMA. This is especially appropriate for a joint meeting. The booklet, 'Medical and Health Care For All' explains Medicredit and is also useful and may be obtained in quantity free from the ISMA;

"4. It's up to you to inform the members of your county auxiliary on Medicredit—the AMA's answer to national health insurance. How you do it is up to you, but begin NOW! The enclosed literature should also prove helpful, especially the AMA's guidelines for good health insurance. Use them as the basis for a comparison between Medicredit and the other major health insurance bills before Congress. Remember, do call for help from the ISMA or from me. We are anxious to help you get the job done."

Equally as important as becoming informed is becoming involved through IMPAC-AMPAC (Indiana/American Medicine Political Action Committee). If each union member can afford $52 per year as his contribution to COPE (labor's political action group) can we with so much at stake afford any less? If you and your wife are not already members, join today.

Happily, legislation is one area where the Auxiliary and Medical Society work hand in hand. It has been my pleasure to meet and know many of you and to accept this most important challenge.

Most sincerely,
Ruth
(Mrs. G. Beach Gattman)

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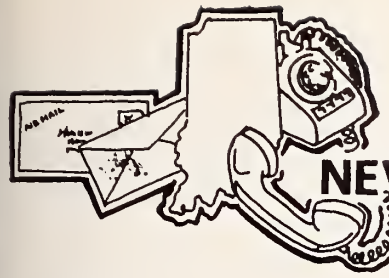
Each tablet contains: aspirin gr. 3½, phenacetin gr. 2½, caffeine gr. ½.
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No. 4 contains codeine phosphate* (64.8 mg.) gr. 1.
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NEWS NOTES

Florida Now May Issue Licenses by Endorsement

Effective September 1, 1971, for the first time in history, the Board of Medical Examiners of Florida may issue licenses by endorsement to practice medicine and surgery in Florida. An amendment to the Medical Practice Act of Florida enacted by the 1971 legislature allows issuance of licenses by endorsement to those M.D.s who have been certified by the National Board of Medical Examiners or the Federation Licensure Examination (FLEX) within a period of eight years preceding the date of application for licensure by endorsement. Since the effective date is September 1, 1971, this means that an M.D. must have been certified by the National Board of Medical Examiners since September 1, 1963, in order to be eligible initially for licensure by endorsement. As far as other state licensure examinations are concerned, this amendment only applies to those states who use the Federation Licensure Examination (FLEX) as their licensure examination.

In the case of foreign medical graduates, this does not eliminate the requirement that the M.D. have papers of first intention of citizenship and a minimum of one year's residency in the United States plus the Educational Council for Foreign Medical Graduates' certificate of proficiency. A very important feature of the amendment is the provision that a physician who receives a license by endorsement in Florida must practice in the state within a period of three years for a minimum period of one year. If he does not do this, the license will become null and void. Service in the armed forces is exempt during these three years, but internship or residency time is not exempt.

Eighth Annual Symposium Scheduled

Nov. 3, 1971, has been chosen as the date for the Eighth Annual Symposium of the Indiana Academy of General Practice and the Indiana Section, American College of Obstetricians and Gynecologists. The all-day session will be held at the Airport Holiday Inn, Indianapolis, and will feature discussions by the following:

Drs. Joseph J. Rovinsky, New York City; **Charles Echt,** Joe Christian, **James A. Crossin** and Robert Cleary, Indianapolis; and Arnold L. Schroeter, Rochester, Minn.

Dr. Gerald Miller to Head Hospital in Somalia, Africa

Dr. Gerald Miller, Markle, and his wife, Mary, have been appointed by the Eastern Mennonite Board of Missions and Charities for a year of service in Jamama, Somalia.

Dr. Miller will be in charge of a 30-bed hospital, clinic and nursing school in the nation which is on the east coast of Africa.

Dr. Isler Gets U. S. Post

Dr. Nathaniel C. Isler, Jeffersonville, has been appointed special projects consultant to Richard L. Roudebush, former Indiana congressman who is now U. S. assistant deputy administrator for veterans affairs.

Two Pediatricians to Receive Mead Johnson Company Awards

Two prominent pediatricians have just been announced as the recipients of the E. Mead Johnson Awards for outstanding research in pediatrics. Paul G. Quie, M.D., of the University of Minnesota and Fred S. Rosen, M.D., of Harvard Medical School will receive the awards, consisting of $3000, a scroll and a certificate, at the annual meeting of the American Academy of Pediatrics, October 16 to 21 in Chicago.

Heads Industrial Health Committee

Dr. E. Lain Tetrick, Portage, has been named chairman of the American Iron and Steel Institute's committee on industrial health.

Tells of Need for Organ Donors

Dr. Stuart Kleit, Indianapolis, spoke at the annual convention of the Indiana Business and Professional Women on the need of transplant organs for kidney disease patients and explained the use of donor cards.

Drs. Robbins, Hall Author Handbook

Drs. Lewis C. Robbins, chief of health hazard appraisal at Methodist Hospital, Indianapolis, and **Jack H. Hall,** director of medical education, Methodist Hospital Graduate Medical Center, are the authors of a new instructional handbook titled "How to Practice Prospective Medicine."

Speaks at Greensburg

Dr. Paul F. Muller, Indianapolis, medical director of St. Vincent Hospital, appeared on a program relating to newborn and high-risk infants, as well as obstetrical and gynecology patients, at Greensburg recently.

Named Health Officer

Dr. J. R. Matthew, Knox, has been appointed Starke County Health Officer. He replaces **Dr. Clark McClure,** who moved to Valparaiso recently.

On Madison County Program

Dr. William J. Gray, Anderson, will be one of the speakers on the six-week night course on drug abuse offered by the Madison County Mental Health Association in cooperation with the Madison County Council on Drug Abuse.

Welborn Hospital Staff Elects

Drs. William C. H. Grimm and Robert D. Boone, Evansville, were chosen president-elect and president, respectively, of the medical staff at Welborn Baptist Hospital recently. Others elected to the executive committee include **Dr. J. Bruce Cox,** secretary-treasurer, **Drs. Larry H. Beisel, Alfred Lessure and Theodore Pavlick.**

Dr. Culbertson Retires



Dr. Clyde Culbertson, research consultant to Eli Lilly and Company, is retiring after more than 25 years of work in the biological research division.

Before joining Lilly he was director of the bacteriology laboratory of the Indiana State Board of Health and director of the clinical laboratory of the Indiana University School of Medicine. He has held the title of clinical professor of pathology at the medical school and was a member of the Editorial Board of *The Journal* for several terms. He will continue to live at his home near Nashville.

Dr. Elshout Named County Physician

Dr. Clement H. Elshout, LaPorte, has been appointed county physician. He succeeds **Dr. Lowell Durham,** who resigned recently.

Attend American Legion Convention

Doctor and Mrs. Lester D. Bibler attended the National American Legion Convention in Houston, Texas, from August 28 to September 2, 1971.

Doctor Bibler was a delegate from the 11th District of the Indiana Department of the American Legion.

Dr. Shriner on Program

Dr. William C. Shriner, Terre Haute, medical director of the Katherine Hamilton Mental Health Center, was one of the participants in a recent program intended to help parents of mentally retarded and developmentally disabled children to gain further understanding of the various federal and state and local agencies which may be of assistance.

Dr. Lehman on Hospital Program

Dr. K. M. Lehman, Topeka, spoke at a refresher program for nurses presented by the LaGrange County Hospital nursing department recently.

Speaks to Retired Persons

Dr. C. E. Snyder, Washington, presented a program on cardiac intensive care at the September meeting of the Daviess County chapter of the American Association of Retired Persons.

Jaycees Name Dr. Nowlin

Dr. William Nowlin, Gary, was reappointed recently to serve as chairman of the Indiana Jaycees statewide emergency medical service program.

Rochester Surgeon Honored

Dr. F. Richard Walton, Rochester, will read a paper on "The Expanding Role of the Specialist in the Small Community Hospital" at the 47th anniversary congress of the Pan American Medical Association. Coincident with the acceptance of the paper is an invitation to Dr. Walton to become a diplomate of the association.

PMA Motion Picture to Have Nationwide Distribution

A 28½-minute color motion picture produced for the Pharmaceutical Manufacturers Association has been released for showing on television and to general audiences nation-wide.

"Mr. Galen Comes To Town," made on location in Hollywood, combines entertainment with pertinent and timely information about modern advances in drug therapy.

The main character is the ancient Roman physician, Galen of Pergamum, who is projected into the 20th Century. Portrayed by the distinguished character actor, Henry Jones, Galen encounters the panorama of people and institutions that make up the system under which modern-day medicines are discovered, produced and used. About half of the action takes place inside a community pharmacy in a small New York town, with Regis Toomey in the role of a pharmacist.

"It is a human, sometimes humorous, low-key introduction to the pharmaceutical industry and what it means to mankind," said C. Joseph Stetler, president of the PMA.

Stetler estimated that six million people would see the picture via showings on approximately 150 television stations alone during the next 12 months. The audience is being expanded by making prints available to every variety of audience, including school, club, church and other groups.

Requests (including television) for free bookings should be addressed to: Modern Talking Picture Service, 2323 New Hyde Park Road, New Hyde Park, N.Y. 11040.

TB Seminar Planned

Drs. Glen Ramsdell, Richmond, and Norman J. Wilson, Gary, were among the speakers at the "Tuberculosis Today" seminar for nursing personnel held Sept. 30 at St. Anthony's Hospital, Michigan City.

Purdue Appoints Dr. Wagner

Dr. Lindley H. Wagner, Lafayette, has been appointed Purdue's director of medical education, according to a recent announcement by Purdue President Arthur G. Hansen. He will continue to serve as director of medical education of Lafayette Home and St. Elizabeth hospitals.

Named to IU Board of Trustees

Dr. William G. Bannon, Terre Haute, has been appointed to the Indiana University Board of Trustees by Governor Edgar D. Whitcomb.

Drug Abuse Booklet Offered

"A Federal Source Book: Answers to the Most Frequently Asked Questions about Drug Abuse" is a 30-page booklet compiled by the National Clearinghouse for Drug Abuse Information to provide answers to the common questions on drug abuse and to provide a glossary of terms. The booklet may be obtained at 25 cents a copy or at the rate of $18.75 per 100 copies by writing Superintendent of Documents, Dept. D, Government Printing Office, Washington, D.C. 20402.

Tulane Seminar at Indianapolis

The Tulane Medical Alumni Association is planning a medical seminar in Indianapolis November 10 to 13, a feature of which will include a chance to see the Tulane-Notre Dame football game at South Bend.

Dr. H. P. Graessle Retires

Dr. H. P. "Bud" Graessle, who has been a surgeon and general practitioner in Seymour since 1918, retired from active practice July 31. He is a member of the 50-Year Club of the Indiana State Medical Association.

Speaks to Medical Assistants

Dr. Herbert Trier, Fort Wayne psychiatrist, discussed "The Couch in Fact and Fantasy" at the September meeting of the Twelfth District Medical Assistants Association.

Eli Lilly and Company Seeks Declaratory Judgment on Product

Eli Lilly and Company has asked the United States District Court for a declaratory judgment that the marketing of Acidulin® is not in violation of the Federal Food, Drug and Cosmetic Act. Despite the fact that the preparation has been prescribed during the last year by at least 5,000 physicians for as many as 50,000 patients, the FDA has ordered it withdrawn from the market. Lilly spokesmen stated that they did not want to deprive physicians and patients of a medication that has been found useful, and said that the significance of the product is in the field of therapy, not economics, since the market is small in relation to total sales.

Hoosier Physicians Named ABFP Charter Diplomates

A number of Indiana physicians have been named charter diplomates of the American Board of Family Practice as a result of passing a certification examination. The list, by counties, includes:

Decatur: **Dr. Robert P. Acher, Greensburg.**

Delaware: **Drs. Ross L. Egger, Middletown, Warren Bergwall and Charles R. Alvey, Muncie.**

Elkhart: **Drs. George R. Bloom and Burton E. Kintner, Elkhart, and Jack C. Clark, Syracuse.**

Fulton: **Dr. Joseph D. Richardson, Rochester.**

Hancock: **Drs. James T. Anderson and Wayne Endicott, Greenfield.**

Howard: **Drs. Richard Carl Fretz, Warren M. McClure and Richard Paul Miethke, Kokomo.**

Jasper: **Dr. Paul Alan Williams, Rensselaer.**

Johnson: **Dr. Mac C. Roller, Franklin.**

Lawrence: **Dr. Joseph D. McPike, Bedford.**

Orange: **Dr. Charles X. McCalla, Paoli.**

Porter: **Drs. Milton R. Carlson, Portage, Robert L. Koenig, Valparaiso, and John A. Forchetti, Chesterton.**

St. Joseph: **Drs. Robert Fenstermacher and Bryce Rohrer, Walkerton.**

Tippecanoe: **Drs. Barton C. Bridge and George M. Underwood, Lafayette.**

Vanderburgh: **Drs. Donald F. Buehner, R. W. Nicholson, Jr., Julian D. Present, Robert F. Walter and John David Wilson, Evansville.**

Wabash: **Drs. Richard and Robert LaSalle, Wabash.**

The list of charter diplomates released by the ABFP, the 20th specialty board approved by the American Medical Association and the American Board of Medical Specialties, includes successful candidates from the first certification examination given in 1970, as well as those passing this year's examination.

The ABFP is unique among certifying boards because it offered no "grandfather clause" which allows doctors practicing in the specialty when a board is created to become diplomates of that board without examination. ◄

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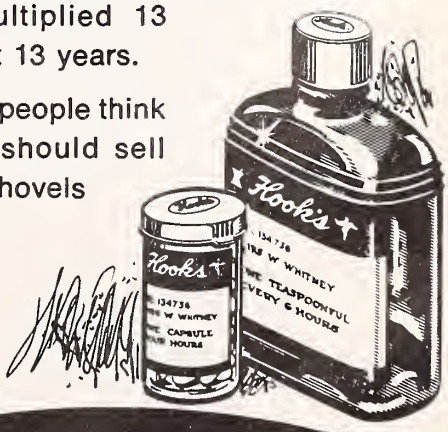
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Lawrenceburg 47025

ALLEN
Louis F. Romain, M.D.
3124 East State Blvd.
Fort Wayne 46805

LAWRENCE
Eugenio N. Tan, M.D.
1805 O Street, Apt. 5
Bedford 47421

MARION
Theron A. Ebel, M.D.
7001 Hoover Road
Indianapolis 46260
Philip N. Eskew, Jr., M.D.
3311 Van Tassel Drive
Indianapolis 46240
Patricia L. Hartlage, M.D.
401 East 34th Street
Indianapolis 46205
John E. Jesseph, M.D.
1100 W. Michigan Street
Indianapolis 46202
Randolph W. Jones, M.D.
2416 North Capitol Ave.
Indianapolis 46208

PORTER
Surjit S. Patheja, M.D.
% Porter Memorial Hospital
814 LaPorte Ave.
Valparaiso 46383

ST. JOSEPH
Edward L. Heyde, M.D.
110 West Bartlett
South Bend 46601

SHELBY
James M. Lorber, M.D.
120 W. Jackson, #4
Shelbyville 46176

TIPPECANOE
David M. Alstott, M.D.
2400 South Street
Lafayette 47904

VANDERBURGH
Donald C. Buehner, M.D.
3700 Bellemeade Ave.
Evansville 47715

About Our Cover

The illustration on this month's cover is of Indiana's newest hospital facility which will be in operation November 1.

Spanning more than two centuries of medical progress, the City of Vincennes, Knox County and the surrounding areas will open a new $11 million addition which, with a completely remodeled 1953 section, should enhance area health care to new levels of excellence. The total book value of the entire complex will be about $14,000,000.

A completely new Mental Health and Psychiatric Unit has been added. This will service three, possibly four surrounding counties.

Television monitoring and the extensive use of television for teaching has been incorporated into the planning. Color television connections to classrooms on each floor and to the Vincennes University School of Nursing building on the campus several miles distant, as well as closed circuit connections to the TV Educational facilities at Indiana University Medical School, have been completed and will become part of an already established continuing education program for hospital personnel.

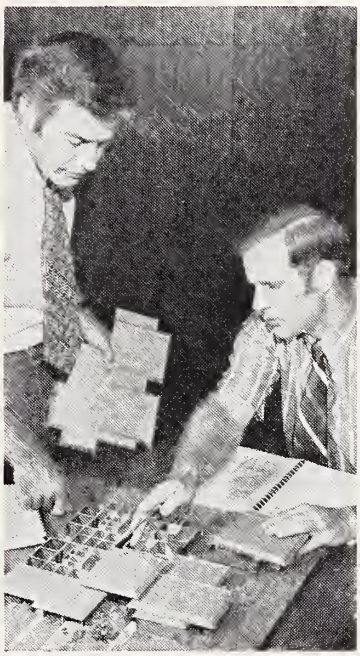
Fortunately, throughout its history there has been superb cooperation and sensitivity between the Board of Governors and the Medical Staff. This has helped create this magnificant new tribute to that good man from Samaria about whom Jesus said "Go and do as he did."—Luke 10:37.

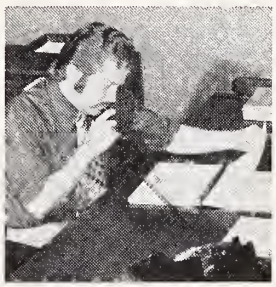
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Deaths

Homer G. Hamer, M.D.

Dr. Homer G. Hamer, Indianapolis, who served on the Nobel Prize Commission in 1934 and the National Research Council in 1941, died August 30 in a nursing home. He was 91.

He had practiced in Indianapolis since 1905 and that same year became clinical professor of urology at the Indiana University School of Medicine, from which he graduated.

A member of the Marion County Medical Society and a Senior Member of ISMA, he served from 1932 to 1952 as a delegate to the AMA.

He had served as secretary and president of the American Urological Association and as president of the American Association of G.U. Surgeons. In addition, he was a member of the American College of Surgeons and a diplomate of the American Board of Urology.

Eldred Frederick Hardtke, M.D.

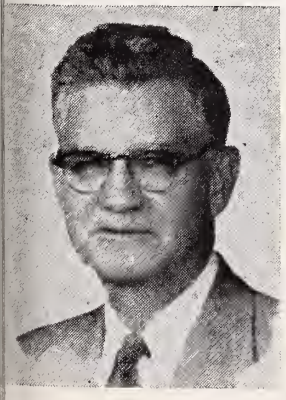
Dr. Eldred F. Hardtke, 57, Bloomington, died July 30. In addition to private practice, he was clinical psychiatrist and associate professor of psychology at the Indiana University psychological clinic.

A graduate of the University of Wisconsin medical school, he served as a medical officer with the U. S. Army from 1948 to 1950.

He had practiced in Indiana since 1950 and was board certified in psychiatry and neurology. In 1958 he served as president of the Owen-Monroe County Medical Society and had served on the ISMA Commission on Medical Economics and Insurance.

Eli Sherman Jones, M.D.

Dr. Eli Sherman (Jack) Jones, Hammond, a former vice president of the American Medical Association, died July 30 in St. Margaret Hospital. He was 81.



He was elected vice president of the AMA in 1966 and was a 50-year member of the Indiana State Medical Association. For a number of years he served as president of the Central States Society for Industrial Medicine and Surgery. He was named a diplomate in Occupational Medicine by the American Board of Preventive Medicine and, in 1964, was honored with the Knudson Award in Occupational Medicine by the Industrial Medical Association.

In 1932 he served as president of the Lake County Medical Society.

A graduate of the Indiana University School of Medicine, he was presented with the university's Distinguished Alumni Service Award in 1970.

Cavins R. Marshall, M.D.

Dr. Cavins R. Marshall, 84, Indianapolis, who had been on the staff of Methodist Hospital for 60 years and on the staff of St. Vincent Hospital for 40 years, died August 31 at home.

A 1911 graduate of the Indiana University School of Medicine, he had served on the Indiana State Board of Health from 1928 to 1931.

He was a member of the Marion County Medical Society and was a Senior Member of the Indiana State Medical Association. He also belonged to the Indiana Academy of General Practice.

Joseph Richard Modjeski, M.D.

Dr. Joseph R. Modjeski, 58, Griffith, died August 22.

A member of the Lake County Medical Society, he was a graduate of the University of Illinois School of Medicine and had practiced in Indiana since 1943, except for three years' service with the Army Air Force in the South Pacific and Phillipines in World War II.

Casell A. Mott, M.D.

Dr. Casell A. Mott, 77, the first Negro to complete his internship at St. Joseph's Hospital, South Bend, died in Memorial Hospital September 4.

He was a graduate of Meharry Medical School, Nashville, Tenn., and was a staff member of Memorial, St. Joseph's and Osteopathic Hospitals. Dr. Mott practiced medicine for 49 years, 45 at South Bend and four years at Michigan City.

David D. Oak, Sr., M.D.

Dr. David Daniel Oak, Sr., 88, who practiced at LaCrosse for 50 years before his retirement in 1960, died July 29 in a nursing home at LaPorte.

In 1948, Dr. Oak was named Indiana's outstanding general practitioner and the following year was the subject of a Ralph Edwards' "This Is Your Life" television show.

A graduate of the Rush Medical College in 1910, he was a veteran of World War I. He was a member of the LaPorte County Medical Society and the American Academy of General Practice and was a Senior Member of the Indiana State Medical Association.

George L. Regan, M.D.

Dr. George L. Regan, 62, Sellersburg, died June 22 at Methodist Evangelical Hospital, Louisville.

A former president of the board of directors of the Clark County Health Department, he was a World War II veteran and had received the Bronze Star.

He was a graduate of the University of Louisville School of Medicine with the class of 1934 and was a member of the Clark County Medical Society.

William David Scharbrough, M.D.

Dr. William D. Scharbrough, 56, Ewing, died July 22 in Indianapolis.

Dr. Scarbrough received his medical degree from the Indiana University School of Medicine in 1950 and was chief of staff at the Jackson County Schneck Memorial Hospital at the time of his death. He had practiced at Medora and Brownstown and was recently re-elected to active membership in the American Academy of General Practice. He was a member of the Jackson-Jennings County Medical Society and was a member of the ISMA Commission on Medical Economics and Insurance.

Charles Lloyd Warner, M.D.

Dr. Charles L. Warner, Evansville, director of Welborn Baptist Hospital's medical education department, died in the emergency room at Welborn September 1. He was 50.

A graduate of the Vanderbilt University School of Medicine, he joined the Welborn staff as a pediatrician in 1953. He was a diplomate of the American Academy of Pediatrics.

Elsie Zeps, M.D.

Dr. Elsie Zeps, 56, of New Castle, died July 25 at the Indiana University Hospital at Indianapolis.

An anesthesiologist, she had been at New Castle for two years, prior to which she had been associated with a hospital at Richmond. Before that she had been with the Indiana State Board of Health at Indianapolis.

She graduated from the Indiana University School of Medicine in 1949 and was a member of the Henry County Medical Society. ◄

County, District News

Eleventh District

The 11th District annual meeting on September 15 was well attended by members, wives and guests.

Dr. John Elleman, Kokomo, is the new president of the District; Dr. Fred Poehler, LaFontaine, continues as secretary-treasurer; Dr James A. Harshman, Kokomo, was re-elected alternate trustee; and Dr. Marcene Pearcy, Marion, was renamed Blue Shield board representative.

Thirteenth District

Dr. H. Dale Pyle, South Bend pediatrician who is retiring and moving to Arizona, and Mrs. Pyle were honored at the September 8 meeting of the Thirteenth District Medical Society.

Speaker of the evening was Mr. Willis Roose, director of the Division of Drug Control, Indiana State Board of Health, whose topic was "The Hoosier Drug Scene."

Thirty-seven members were present for the business meeting at which the following officers were chosen for the coming year: President, Frank McGue, Michigan City; president-elect, James Rimel, Plymouth; secretary-treasurer, David Spalding, Mishawaka; trustee, G. Beach Gattman, Elkhart; and alternate trustee, Donald Chamberlain, South Bend.

Bartholomew-Brown

Thirty-nine members were present at the Harrison Lake Country Club for the September 8 meeting of the Bartholomew-Brown County Medical Society.

Election of officers resulted in a new president, Dr. C. David Ryan, Columbus, taking office. William L. Pearcy, Columbus, will continue to serve as secretary.

Guest speaker was Mr. Richard H. Bohn, executive director of Region II, Comprehensive Health Planning Council, Inc., which serves Bartholomew, Brown, Decatur, Jaekson and Jennings counties. After a talk by Mr. Bohn, a question-and-answer period ensued.

Dearborn-Ohio

"Epilepsy" was the subject of the paper presented at the September 2 meeting of the Dearborn-Ohio group at the Dearborn Country Club, Aurora, by Dr. Harold Fogelson of the department of Pediatrics, University of Cincinnati, and the Children's Hospital Medical Center.

Greene

The Greene County Medical Society met September 9 with 15 members present.

A Mr. Collins of Blue Cross Hospital Service explained Medicare relative to hospital stays.

It was announced that the 1972 meeting of the Second District would be held May 18 in Linton.

Knox

Dr. Joe Dukes, second district trustee, attended the meeting of the Knox County Medical Society on September 21.

A resolution was passed for introduction in the House of Delegates relative to the reimbursement of committee members for time spent at both the hospital and nursing home level on Medicaid and Medicare programs.

It was announced that the County Society had given up its own blood bank program and has joined the Red Cross blood bank program.

Jefferson-Switzerland

Twenty-two members of the Jefferson-Switzerland County Medical Society met at the Key West Shrimp House, Madison, on September 7.

During the business meeting concern was expressed with regard to the Willkie "physician transplant" program, and Dr. Joe Dukes, ISMA board Chairman, who was present, was instructed to urge that the Willkie group devote considerable effort to convincing Indiana medical graduates to practice in Indiana.

Tippecanoe

When the Tippecanoe County Medical Society met on September 14 at The Trails, 53 members and 11 guests were in attendance.

The next meeting will be held at Wabash Center Nov. 9 at 6:00 p.m.

Wells

Members and 10 physician guests of the Wells County Medical Society met September 9 for a continuing education program.

Drs. Arthur Norins and Warren Epinette of the Indiana University School of Medicine gave the program which consisted of slides, lecture and a question-and-answer session on "Progress in Dermatology."

It was announced that the October 25 meeting would pertain to medical-legal matters. ◄

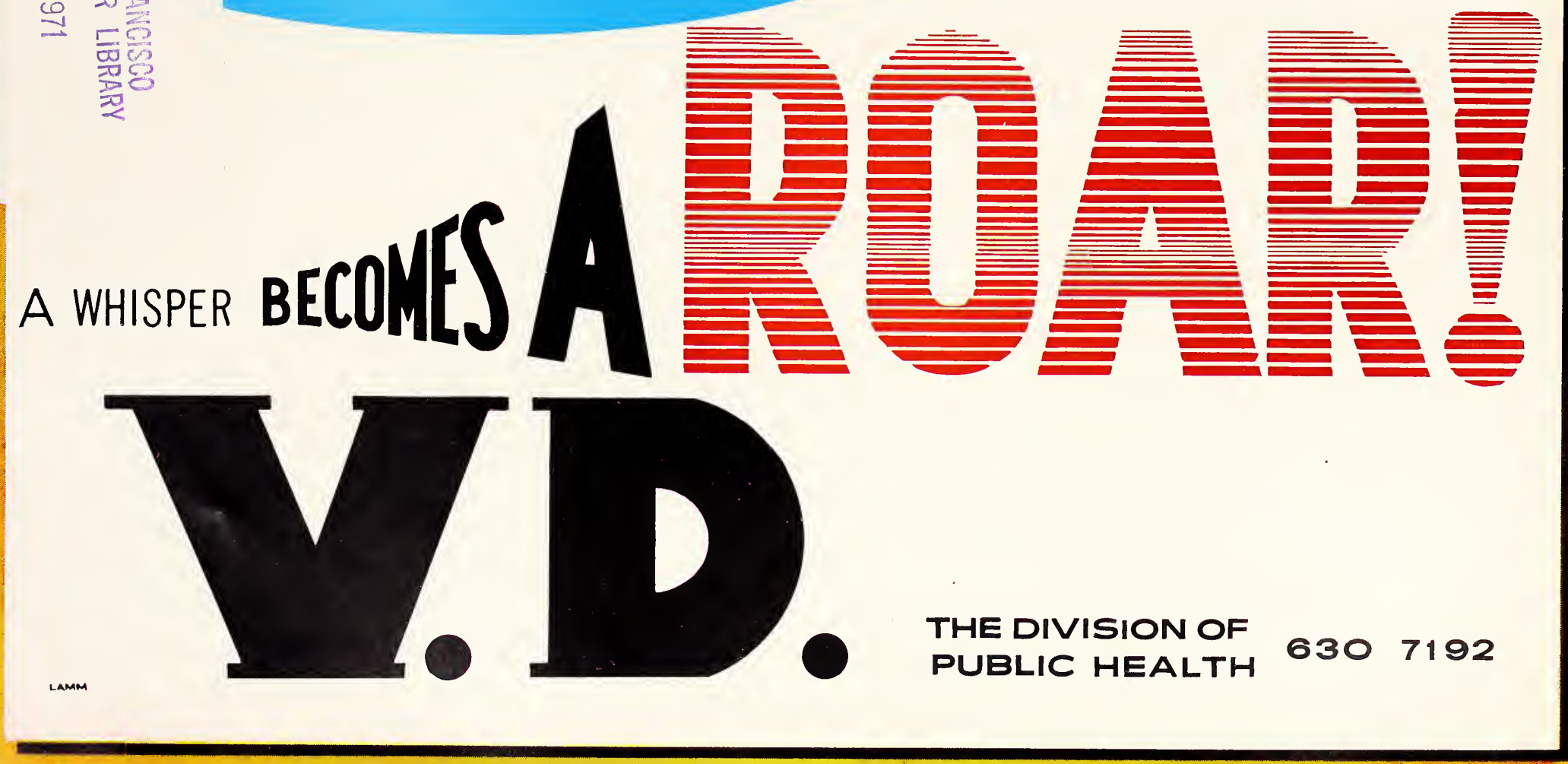
From *The Journal* 50 Years Ago

Today every laryngologist is expected to be able to remove foreign bodies not only from the larynx, but also from the trachea, bronchi and esophagus. Many of you who are familiar with the brilliant achievements of Chevalier Jackson through journal reports, or who have been so fortunate as to witness his marvelous technique in bronchoscopy, scarcely realize the expenditure of time, labor and money necessary to attain such perfection. It seems so easy for Paderewski to render a great masterpiece of music like the Emperor Concerto, of Beethoven, that we are apt to forget the study and labor of years necessary for even his splendid genius to produce such art. Perhaps there is no surgical procedure in which every detail of technique is so important and perfectly trained assistants are so essential, combined with constant practice on the part of the operator, as in the removal of foreign bodies from the bronchi and esophagus.

. . . A number of tragedies are on record, and many more unrecorded, of brutal efforts to remove foreign bodies from the esophagus and air passages without knowledge or experience. On the other hand, the danger is very slight and the fatalities are very rare in the use of these instruments in the hands of the skillful and judicious, while the results in the saving of life are among the most frequent and dramatic in the field of surgery. . . . Lafayette Page, M.D., Indianapolis, "The Removal of Foreign Bodies from the Air and Food Passages," *JISMA*, October 1921.

JOURNAL
OF THE INDIANA STATE MEDICAL ASSOCIATION
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Indianapolis, Indiana

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Patients fell asleep quickl

Dalmane (flurazepam HCl) 30 mg reduced awake time—both before and after falling asleep - by fifty percent of pretreatment values in patients with insomnia.[1,2]

Two sleep laboratory studies recently confirmed findings of earlier studies of this type, namely, that Dalmane 30 mg was effective in patients who had trouble falling asleep, staying asleep or both. One 30-mg capsule of Dalmane usually induced sleep within 22 minutes, decreased the number of awakenings and the wake time after the onset of sleep, and provided 7 to 8 hours of sleep without need to repeat dosage during the night.

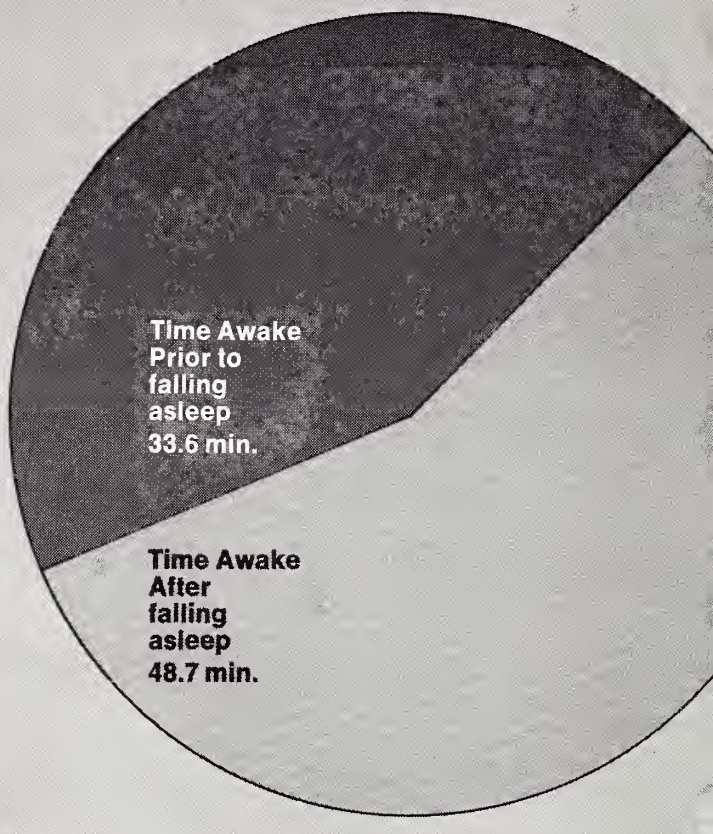
These studies utilized identical protocols and included eight insomniac patients. Sleep laboratory measurements in a limited number of patients are derived from all-night electro-encephalographic, electro-oculographic and electromyographic tracings. Unlike traditional methods of evaluation, they are quantitative, reproducible and projectable to large numbers of subjects.

Results shown represent average values in all subjects for the three consecutive nights of placebo administration prior to Dalmane therapy and the seven consecutive nights on Dalmane 30 mg.

Dalmane is also relatively safe, as reported in clinical studies. Instances of morning "hang-over" have been relatively infrequent; paradoxical reactions (excitement) and hypotension have been rare. Dizziness, drowsiness, lightheadedness and the like were the side effects noted most frequently, particularly in the elderly or debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

References: 1. Frost, J. D., Jr.: "A System for Automatically Analyzing Sleep," Scientific Exhibit presented at Clinical Convention, A.M.A., Boston, Nov. 29-Dec. 2, 1970, and Aerospace M.A., Houston, April 26-29, 1971.
2. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J.

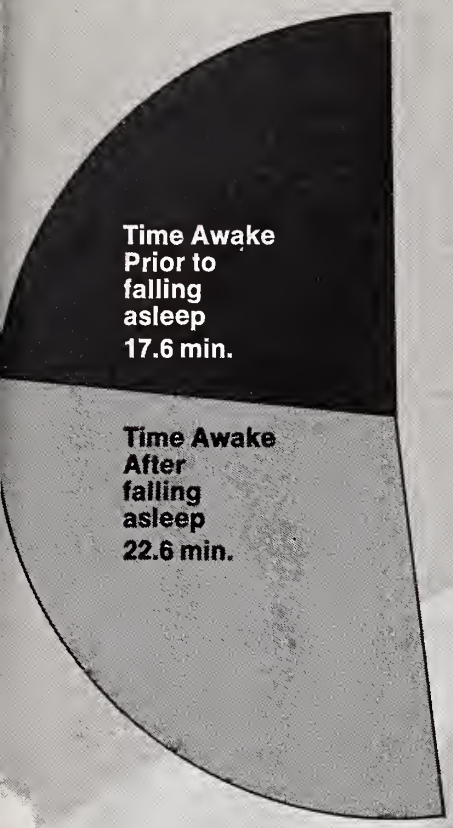
Before Dalmane (flurazepam HCl)



Measurements of sleep in the sleep laboratory are obtained with electroencephalographic, electro-oculographic and electromyographic recordings.

ınd slept through the night

On
Dalmane
flurazepam HCl)



leep laboratory measurements in cited studies

r	Before Dalmane	On Dalmane
ıired to fall asleep	33.6 min.	17.6 min.
e after onset of sleep	48.7 min.	22.6 min.
of wakeful periods after et of sleep	12.2	8.4
sleep time	420.0 min.	447.5 min.
sleep percent	88.6	94.5

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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NOVEMBER 1971

The Journal
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All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

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on page 1253

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4—Jack E. Shields, Brownstown	Oct. 1974
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6—Paul M. Inlaw, Shelbyville	Oct. 1973
7—Jahn O. Butler, Indianapolis	Oct. 1974
7—Dwight W. Schuster, Indianapolis	Oct. 1972
8—Richard Ingram, Montpelier	Oct. 1972
9—William M. Sholty, Lafayette	Oct. 1973
10—Vincent J. Santare, Munster	Oct. 1974
11—Lawell Hillis, Laganspart	Oct. 1972
12—William R. Clark, Fart Wayne	Oct. 1973
13—G. Beach Gattman, Elkhart	Oct. 1974

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1—Raymond Newnum, Evansville	1973
2—Betty Dukes, Dugger	1974
3—Thamas Neathamer, Jeffersanville	1974
4—Haward C. Jackson, Madison	1973
5—Clean M. Schauwecker, Greencastle	1973
6—	
7—Jaseph F. Ferrara, Franklin	1972
7—Jaseph C. Kerlin, Danville	1972
8—R. D. Williams, Anderson	1973
9—Max N. Hoffman, Covington	1974
10—Thomas C. Tyrrell, Hammand	1972
11—James A. Harshman, Kokoma	1974
12—Walter D. Griest, Fart Wayne	1974
13—Danald S. Chamberlain, Sauth Bend	1973

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Jahn Farquhar, Fort Wayne	Thomas C. Tyrrell, Hammond

Terms expire December 31, 1972:

Delegates	Alternates
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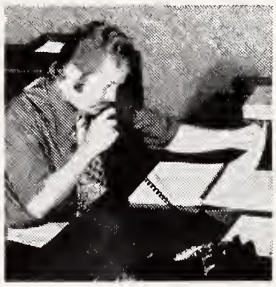
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3.	Daniel H. Cannon, New Albany	Charles X. McCalla, Paoli	April 5, 1972, Clarksville
4.	Rabert O. Zink, Madison	Ott B. McAtee, Madison	May 17, 1972, Madisan
5.	Burtan E. Scherb, Terre Haute	James W. Cristee, Terre Haute	May 4, 1972
6.	Mark E. Smith, New Castle	James H. Tower, Jr., Shelbyville	May 3, 1972, Shelbyville
7.	Jahn M. Recards, Franklin	Merrill M. Weseman, Franklin	June 14, 1972, Franklin
8.	Franklin K. Beeler, Anderson	Edward R. Rush, Anderson	
9.	Don W. Boyer, Lebanan	Clarence G. Kern, Lebanan	June 28, 1972, Lebanan
10.	Lambra Dimitroff, Hammand	Danald C. Miller, Cedar Lake	
11.	Jahn Elleman, Kokoma	Fred Paehler, La Fontaine	Kokomo
12.	George C. Manning, Fart Wayne	William B. Hughes, Waterlao	September, 1972
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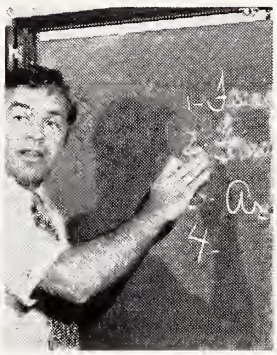
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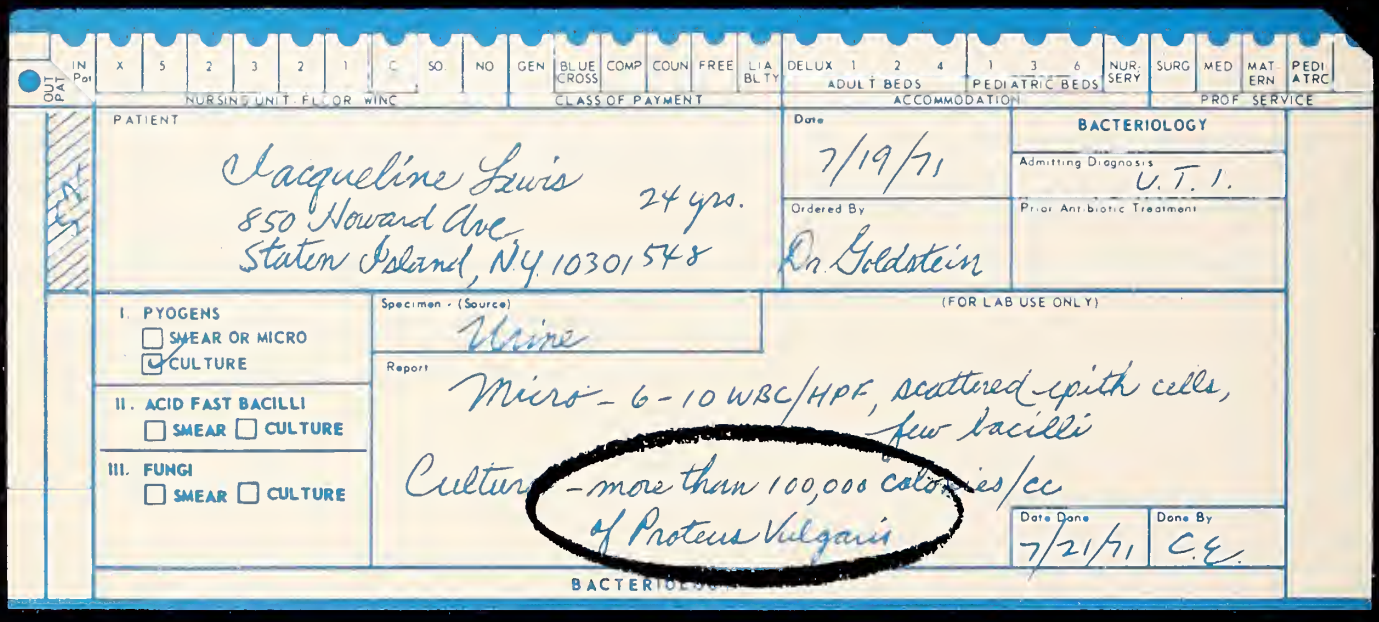
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PATIENT

Jacqueline Lewis 24 yrs.
850 Howard Ave
Staten Island, N.Y. 10301 548

Date: 7/19/71

BACTERIOLOGY

Admitting Diagnosis: U.T.I.

Ordered By: Dr. Goldstein

Prior Antibiotic Treatment:

I. PYOGENS
☐ SMEAR OR MICRO
☑ CULTURE

II. ACID FAST BACILLI
☐ SMEAR ☐ CULTURE

III. FUNGI
☐ SMEAR ☐ CULTURE

Specimen - (Source): Urine

(FOR LAB USE ONLY)

Report:
Micro - 6-10 WBC/HPF, scattered epith cells, few bacilli
Culture - more than 100,000 colonies/cc of Proteus Vulgaris

Date Done: 7/21/71

Done By: C.E.

BACTERIOLOGY

the choice is clear:

Pyopen®

(sterile disodium carbenicillin)

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Proteus vulgaris, confirmed by pure culture. Fortunately, the strain proves sensitive to carbenicillin and the patient is not allergic to penicillins. The choice is clear: Pyopen.

Unlike other antibiotics currently available for the treatment of Gram-negative sepsis, there are no reports of nephrotoxicity or ototoxicity with Pyopen therapy. Particularly valuable in urinary infections, because of its exceptionally high urine levels, its effectiveness against *Ps. aeruginosa* and *Proteus* species has been amply confirmed by clinical experience and microbiologic studies.

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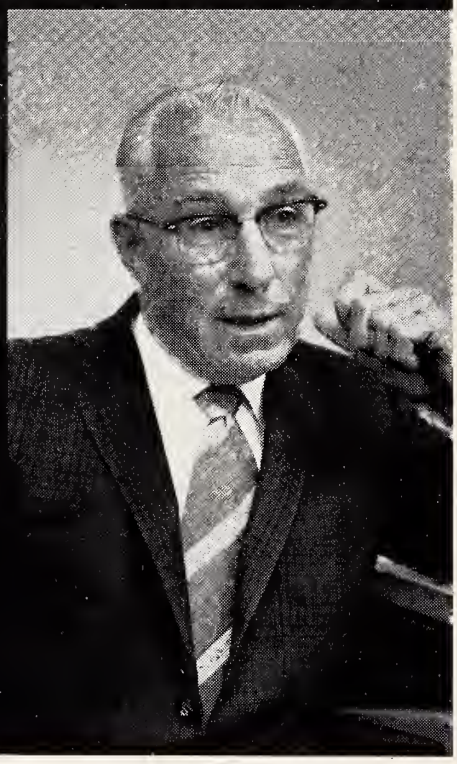
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PRESCRIBING INFORMATION **Indications:** Primarily for treatment of infections due to susceptible strains of *Pseudomonas aeruginosa*, *Proteus* species (particularly indole-positive strains), and certain *Escherichia coli*. Clinical effectiveness has been demonstrated in the following infections when due to these organisms: Urinary tract infections; severe systemic infections and septicemia; acute and chronic respiratory infections (while clinical improvement has been shown, bacteriologic cures cannot be expected in patients with chronic respiratory disease and cystic fibrosis); soft tissue infections. Although PYOPEN (disodium carbenicillin) is indicated primarily in Gram-negative infections, its activity against Gram-positive organisms should be kept in mind when both Gram-positive and Gram-negative organisms are isolated (see Actions). **Note:** During therapy, sensitivity testing should be repeated frequently to detect the possible emergence of resistant organisms. **Actions:** Organisms found to be susceptible *in vitro* include: Gram-Negative Organisms-*Ps. aeruginosa*, *Proteus mirabilis*, *Pr. morganii*, *Pr. rettgeri*, *Pr. vulgaris*, *E. coli*, *Enterobacter* species, *Salmonella* species, *Hemophilus influenzae*, and *Neisseria* species. Gram-Positive Organisms-*Staphylococcus aureus* (nonpenicillinase-producing), *Staph. albus*, *Diplococcus pneumoniae*, Beta-hemolytic streptococci, and *Streptococcus faecalis*. Some newly emerging pathogenic strains of *Herellea*, *Mima*, *Citrobacter*, and *Serratia* have also shown *in vitro* susceptibility. Not stable in the presence of penicillinase. *Klebsiella* species are resistant. Some strains of *Pseudomonas* have developed resistance fairly rapidly. **Contraindications:** Known penicillin allergy. **Warnings:** Serious and occasional fatal hypersensitivity (anaphylactic) reactions have been reported in patients on penicillin therapy. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens. There have been reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, appropriate therapy should be instituted and discontinuance of disodium carbenicillin therapy considered, unless the infection is life threatening and only amenable to disodium carbenicillin therapy. The usual agents (antihistamines, pressor amines, and corticosteroids) should be readily available. **Usage in Pregnancy:** Safety for use in pregnancy has not been established. **Precautions:** As with any other potent agent, it is advisable to check periodically for organ-system dysfunction, including renal, hepatic, and hematopoietic systems, during prolonged therapy. Emergence of resistant organisms, such as *Klebsiella* species and *Serratia* species, which may cause superinfection, should be kept in mind. Each gram contains 4.7 mEq sodium; in patients where sodium restriction is necessary, such as cardiac patients, periodic electrolyte determinations and monitoring of cardiac status should be made. Observe patients with renal impairment for bleeding manifestations and adhere strictly to dosage recommendations. If bleeding manifestations appear, discontinue antibiotic and institute appropriate therapy. As with any penicillin preparation, the possibility of an allergic response, including anaphylaxis, may occur, particularly in a hypersensitive individual. **Administration:** Intramuscular injections should be made well within the body of a relatively large muscle (not into the lower and mid-third of the upper arm), and aspiration is necessary to help avoid inadvertent injection into a blood vessel. May be given by either intravenous injection or intravenous infusion. After reconstitution with Sterile Water for Injection unused portions should be discarded after 24 hours if stored at room temperature, or after 72 hours if refrigerated. **Adverse Reactions:** *Hypersensitivity Reactions*—Skin rashes, eosinophilia, pruritus, urticaria, drug fever, and anaphylactic reactions. *Gastrointestinal Disturbances*—Nausea. *Hemic and Lymphatic Systems*—Hemolytic anemia, thrombocytopenia, leukopenia, neutropenia, in uremic patients receiving high doses (24 gm/day), hemorrhagic manifestations associated with abnormalities of coagulation tests, such as clotting and prothrombin time. *Hepatic and Renal Studies*—SGOT and SGPT elevations have been observed, particularly in children. To date, no clinical manifestations of renal disorders have been demonstrated. *Central Nervous System*—Convulsions or neuromuscular irritability could occur with excessively high serum levels. *Local Reactions*—Pain at the site of injection, sometimes accompanied by induration. Vein Irritation and Thrombophlebitis—particularly when undiluted solution is injected directly into the vein. **How Supplied:** Available in 1 Gm. and 5 Gm. vials.
Before prescribing or administering, see package circular or PDR.

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When I look back at some of my old records, I'm constantly reminded of the changes that have come about in medicine just during the past twenty-five years. Some of the diseases I treated and prayed over in the '40's are found mostly in medical history books now.

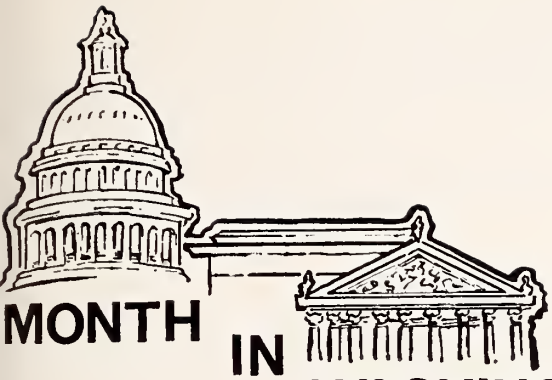
Thanks to drug research and development, we've made substantial gains in the control of cardiovascular disease, diabetes, malaria, mental illness, strep and staph infections, meningitis and a long list of ailments. It seems like only yesterday when a diagnosis of pneumonia was almost the kiss of death. Now, with modern medical techniques and drug therapy, we can offer some real help.

My records on polio, influenza and measles show an unbelievable trend for the better. New vaccines have reduced the toll of these age-old threats dramatically. And I see patients in pain from crippling arthritis helped with new medicinals unknown just a few years ago.

I hear questions about the three billion or so dollars spent by the drug industry in research during the past ten years . . . working on new and better drug products. It does seem like quite a bit of money to spend, and I realize some of it goes into dead ends. That's the problem with research, any research . . . you often don't know where you're going until you get there. I want all the tools I can get to help my patients. I want more drugs and more effective drugs. If they mean less pain, longer lives and more productive careers for those I treat . . . well, that's what really counts.

Another point of view . . . Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.

This advertisement has been reaching consumers thru THE ATLANTIC, FAMILY HEALTH, HARPER'S MAGAZINE, NEWSWEEK, SATURDAY REVIEW, TIME and U.S.NEWS & WORLD REPORT.



MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the first of each month preceding month of issue.

HEALTH, EDUCATION and Welfare Secretary Elliot L. Richardson approved a proposed regulation to authorize insurance carriers to issue contracts for prepaid group medical service to persons in any state regardless of any restrictive state law.

AUTHORITY for the proposed regulation was granted by Congress last year in a law sponsored by Sen. Edward M. Kennedy (D. Mass.), who also is the chief Congressional sponsor of organized labor's all-out national health insurance proposal. Under the terms of the law, the HEW secretary can authorize insurance carriers who provide coverage through the Federal Employee Health Benefits program to issue contracts for group medical services.

FORTY-ONE PRIME health insurance carriers presently provide coverage through FEHBP. The actual number of insurance carriers affected by the law could total in the hundreds because of re-insurance contracts between prime carriers and other insurance providers, according to a spokesman for the department's Office of Group Practice Developments.

THE REGULATION allows the HEW secretary to authorize the insurance companies "to issue in any state contracts entitling any person as a beneficiary to receive comprehensive medical services from a group practice unit or organization" with which the company has contracted for the provision of group services.

THE proposed regulation would be to override those restrictions "enabling insurance carriers to issue contracts for prepaid group medical services to any individual in any state," an HEW announcement said.

HEW SAID as many as 50 million residents of the 20 states with laws restricting group practice could become eligible for group health plans.

SUCH PLANS, as described in the proposed rules, offer preventive, diagnostic and therapeutic medical services in a single organization on a prepaid basis.

"A MEDICAL GROUP . . . shall include at least a general practitioner and representatives of each of the following medical specialties: general surgery, obstetrics, internal medicine, pediatrics

Continued

and ear-nose-throat," the proposal said.

KENNEDY applauded HEW's move but criticized the delay.

"THE CAUSE of the delay is no secret," he said in a statement. "For months the profitmaking commercial industry fought to obtain a larger role."

HE SAID THAT, while the intent of Congress prevailed, the delay shows "the virtual stranglehold the health insurance lobby has on this administration."

WANT CANCER RESEARCH RETAINED WITHIN NIH

THE AMERICAN Medical Association told Congress that the attack on cancer can be most effectively conducted through the National Cancer Institute within the National Institutes of Health, rather than through a separate and autonomous agency.

TESTIFYING before the House Health and Environment Subcommittee, Franz J. Ingelfinger, M.D., editor of the New England Journal of Medicine and a member of the Advisory Committee on Medical Sciences to the AMA's Board of Trustees, said that "the effort to cure cancer will have to be a coordinated effort with full involvement of all the national institutes (of health)."

"THERE IS ANOTHER compelling reason to retain the cancer program within NIH and that is to keep the NIH intact rather than have it become fragmented into independent agencies," Dr. Ingelfinger said. "Under the latter conditions the agencies would be competing for support and recognition rather than collaborating for scientific progress. The NIH is generally regarded in the international scientific community as one of the most splendid scientific achievements of the 20th century. To impair the effectiveness of this productive organization would be unwise. The integrity of the NIH should be maintained and increased support provided."

DR. INGELFINGER expressed opposition to a compromise measure passed by the Senate which would create a new independent Conquest of Cancer Agency within the NIH. He said that the autonomy proposed for such a new agency would "threaten the structure of the National Institutes of Health and impair research efforts in all fields."

DR. INGELFINGER cautioned against expecting any quick victory over cancer.

"WE BELIEVE . . . that false hopes should not be created and that people should not be led to believe that with enough money and enough effort cancer will quickly be conquered," Dr. Ingelfinger said. "Although many encouraging developments have occurred in the last few years that justify the major national effort proposed in House Bill 10681, the problems to be solved are very complex. Much basic research work remains to be done. Everyone should be prepared for steady but perhaps slow progress. We should also recognize that chance discoveries by scientists working in totally different fields may set the stage for significant future progress. This has occurred repeatedly in the history of scientific discovery, and consequently basic scientific research should be allowed a high degree of individuality and spontaneity.

". . . THE AMERICAN Medical Association advocates a program attacking cancer through greatly intensified and coordinated research efforts.

We believe that in the interests of the public and in order to avoid any splintering of efforts, the program, adequately funded, should be administered within the National Institutes of Health under a director having responsibility for all biomedical research."

AMA'S ATTITUDE ON THREE LEGISLATIVE MATTERS TOLD

OTHER AMA presentations on national legislation:

Physician Shortage Areas

THE AMA SUPPORTED legislation that would provide federal aid to individual or small groups of physicians in establishing medical practices in rural areas, small towns and low income inner city areas.

THE LEGISLATION (S. 2269) would amend the National Housing Act to authorize mortgage insurance for the construction and rehabilitation of medical facilities for the practice of one to four physicians in physician-shortage areas. In 1966, mortgage insurance was authorized for establishment of non-profit group practices. The current legislation would extend that program.

DR. JOHN M. CHENAULT, a member of the AMA Board of Trustees, spoke for the Association. He said: "One of the problems in our health delivery today relates to a shortage of necessary manpower, as well as the lack of proper distribution. The shortage is particularly emphasized in rural areas and areas of low income. The failure of such areas to attract physicians can be attributed to many factors—tangible and intangible—and the problem is a complex one. We should, however, provide incentives and encouragement to physicians to meet the needs of those areas.

"THE AMERICAN Medical Association supports a pluralistic system of delivery of health care embracing various forms of health care delivery. Each type of health care delivery mechanism, including group practice, has its advantages. The group-type of practice, however, is neither feasible nor desirable for all the nation's physicians. . . .

"IT IS READILY apparent that not all areas will attract the same kind of group practice, nor could a rural area support the establishment of the same type of practice as might be set up in larger, more urban communities.

"S. 2269, by providing financing assistance, may help to stimulate the establishment of a medical practice by an individual practitioner or a small group of physicians in small and rural communities and inner city areas having physician shortages.

"IN CONSIDERING these amendments, we believe the provisions in the bill concerning the maximum loan should be reviewed. We recommend that the limitation of $150,000 should be raised so as not to preclude the establishment of a facility with potentially broad health delivery capability where such facility and staff are warranted in a community. The figure proposed in the bill might act to limit construction of beneficial facilities in certain areas."

National Institute for Health Care Delivery

THE AMA QUESTIONED the desirability of establishing a National Institute for Health Care Delivery.

Continued

IN A LETTER to Sen. J. Glenn Beall, Jr. (R. Md.) who made the proposal and invited AMA's comment, Ernest B. Howard, M.D., AMA executive vice president, said:

"AS WE understand your proposal, a National Institute of Health Care Delivery would be established for the purpose of developing improvements in health care delivery, the Institute being perhaps comparable to NIH and NASA. Through the use of "think tanks" and developmental labs, the institute would examine our existing health care system and design and test components of a new one.

"OUR HEALTH DELIVERY system is constantly responding to improvements in medicine as they are developed. These changes occur through many means—the medical schools, university and other hospitals, clinics, continuing education (both formal and informal), and community practices of all types. One of the strengths of our health care system is its pluralistic nature which can absorb and respond to changes as new medical and scientific knowledge is developed.

"YOUR PURSUIT for improvements in our health care delivery is a most laudable one, and one in whose objectives the medical profession shares. We have some reservations, however, as to whether improvements in our health delivery system can respond in the laboratory in the same manner as medical or scientific research or the NASA program. Many of the elements of our health care delivery, some referred to in your comments, are currently under careful examination and experimentation.

"YOUR PROPOSAL would apparently parallel in many respects the National Center for Health Services Research and Development, only recently created, and it is not clear how the two would relate to each other. Perhaps an expansion of activities of the existing center should be the vehicle for the contemplated programs."

Military Medical School

THE AMA OPPOSED establishment of a military medical school.

TESTIFYING BEFORE the House Armed Services Committee, Bland W. Cannon, M.D., a member of the AMA's Council of Medical Education, said:

". . . WE CANNOT emphasize too strongly that our concern is that the men and women in our uniformed services should receive nothing less than the best in medical care. There is no reason why they should not continue to receive care from physicians trained in a medical education system which has proven itself to be unexcelled. We support an expansion and greater utilization of this system rather than the development of a new and different kind of institution. . . .

"ONE ASPECT of the nation's goals for more physicians is the need of the uniformed services, and it is to this one aspect that H.R. 2 is directed. The AMA believes it is vital that the number of physicians in the uniformed services be adequate to enable them to carry out their missions, and that those physicians be thoroughly trained and competent in order that those serving our country in the uniformed services might receive the best possible medical care. However, it is doubtful that these objectives can best be realized through establishment of a

separate uniformed forces medical school, as called for in H.R. 2.

"IN OUR OPINION, it would be very unwise to establish a separate medical school specifically to train physicians for the uniformed services in which all, or a significant portion, of the physicians serving in these forces would receive their medical training. We believe it is very important that the armed forces take full advantage of the resources and facilities of the existing medical schools of the United States in training their medical manpower, and that such training not be restricted in any degree to a single school established for that purpose. We also believe that it would be possible to train larger numbers of physicians in a shorter period of time for a lesser cost if the existing schools were used."

THE AMA supported provisions in the legislation for helping medical students with scholarships with a requirement that they serve on active duty for a number of years after completion of training, and utilizing military medical facilities for the training of future military medical officers.

THE AMA said that, through affiliation agreements between existing medical schools and the armed services, "larger numbers of physicians could be produced for the uniformed services at substantially lower costs, in a shorter period of time, and with the quality of the medical education assured."

DESPITE the opposition of the AMA and the Association of American Medical Colleges, the committee unanimously (31-0) approved the bill. The legislation would authorize a medical student scholarship program of $210 million over the next five years. The military medical school would be built in the Washington area. ◄

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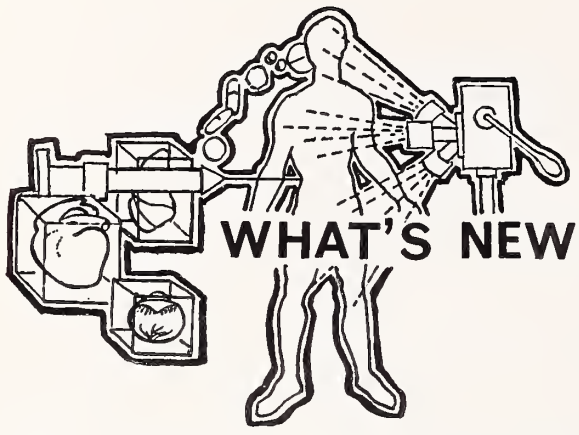
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Future Systems has the world's smallest electrolytic silver recovery system. It is available in five models from 5 to 32 times more compact than conventional equipment. The system will recover up to 99% of the silver from photographic solutions at rates up to 9 ounces per hour. The device prevents the formation of silver sulfide which is the major difficulty with ordinary electrolysis. Recovery of silver from photographic solutions is not only financially advantageous but aids in the conservation of silver which is in short supply due, to a large extent, to the large amounts which are necessary for X-Ray photography.

* * *

Posey is introducing an all-purpose safety belt, the Posey Snubber Belt, for use on stretchers or in the emergency room. Completely washable, it is made of 3″ wide cotton webbing and is 54″ long. It has a snubber buckle which allows quick and easy adjustment anywhere on the belt.

* * *

Wyeth Laboratories are introducing new short-term dry heat and cold therapy bags which are effective for about one hour and may then be discarded. Both comprise dry chemicals and an activating solvent which is released by a light blow to the pack just prior to use. Both have a soft comfortable outer fabric. The name is RediTemp-C cold packs and ditto hot packs.

* * *

IE Industries is introducing a new system of modular cabinets especially for medical use. Functional variations of the units include cupboard and corner units with or without sink, drawer, desk, and wall units. Arrangements may be planned to fit almost any space. Base units are 14 and 25 inches wide, 18 inches deep and 38 inches high. Wall units come in 14 and 25 inch widths and are 11½ inches deep and 19 inches high. All in a variety of colors.

* * *

Mead Johnson announces two new formulations for Vasodilan®. Vasodilan Syrup will be available in strength of 10 mg per 5 ml teaspoonful, and in 10 mg tablets in the unit dose system.

* * *

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers of pharmaceuticals, clinical laboratory supplies, instruments, and surgical appliances and book publishers. Each item is published as news and does not necessarily constitute an indorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

Pre-Sate® (chlorphentermine hydrochloride)

Caution: Federal law prohibits dispensing without prescription.

Indications
Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (i.e. several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.

Contraindications
Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.

Warnings
When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.
Drug Dependence Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with the high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.
Usage In Pregnancy The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.
Usage In Children Not recommended for use in children under 12 years of age.

Precautions
In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorectic agent and a restrictive dietary regimen.

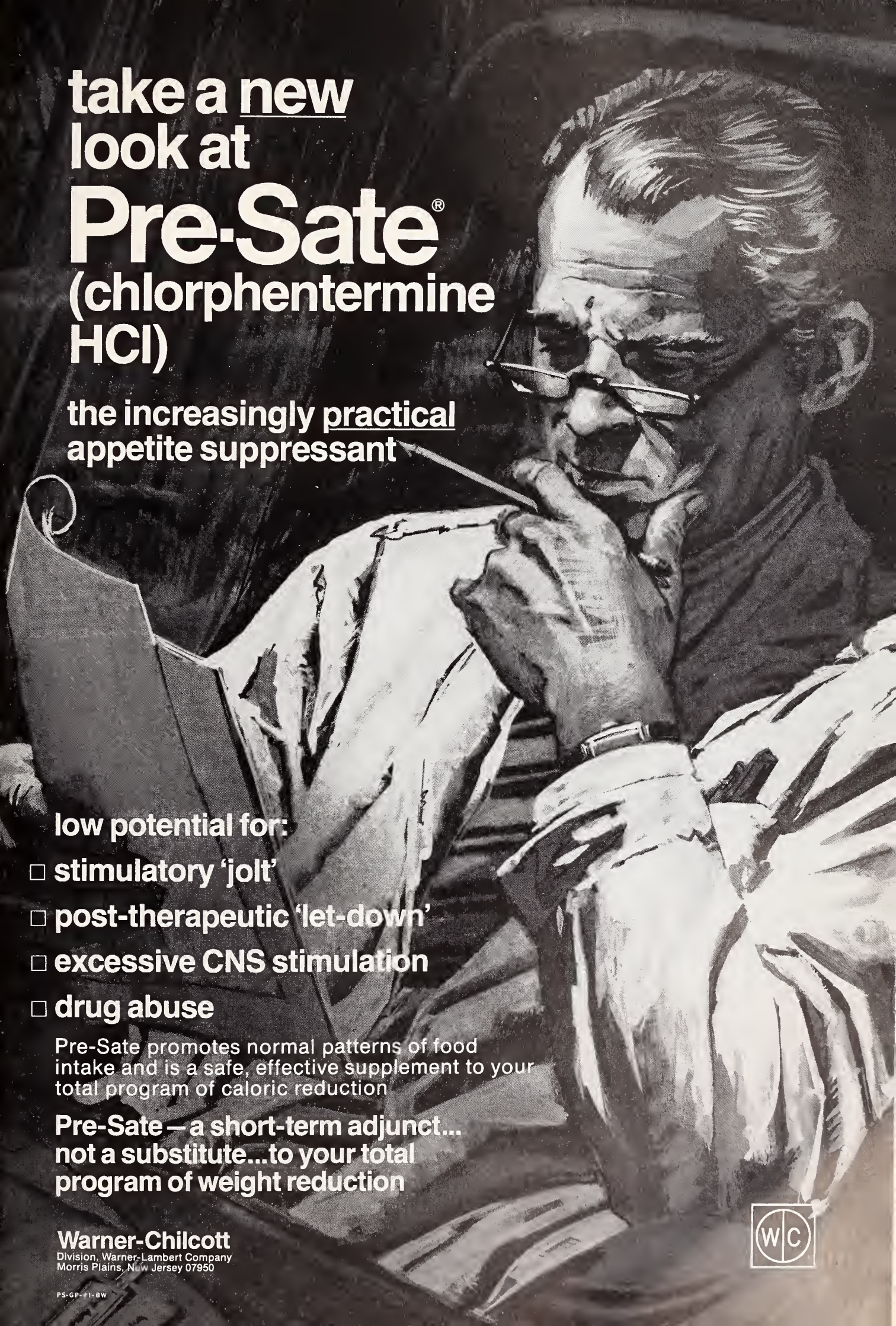
Adverse Reactions
Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.

Dosage and Administration
The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.

Overdosage
Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.
Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

How Supplied
Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.

Full information is available on request.


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Pre-Sate®
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the increasingly practical appetite suppressant
low potential for:
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□ excessive CNS stimulation
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Pre-Sate promotes normal patterns of food intake and is a safe, effective supplement to your total program of caloric reduction
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Letters to the editor

To the editor:

We would like to invite our medical colleagues to become members of our national non-profit organization which is dedicated to furthering art interests of the medical profession; to broadening the physician's knowledge and appreciation of the past and present; to stimulating physician artists to produce works of art in the fields of painting, sculpture, photography, graphic arts, design and creative crafts; to holding a national annual exhibition of physicians' art works; and to stimulating regional art exhibitions of physicians' works at local, state and specialty meetings.

Our art exhibit is held annually in conjunction with the annual meeting of the American Medical Association. The APAA has a membership which extends across the entire United States, Canada and Latin America. Every state in the Union is represented through a Regional Director. It is the hope of the APAA to establish a central photographic archive of its members' art works, to be used for year round press and magazine publicity in the physicians' home towns as well as nationally.

You do not necessarily have to be currently engaged in any art activity to become a member. We also welcome the support of anyone interested in furthering physicians' art in America, as our organization is totally supported by the members and friends of the APAA. The types of membership are:

Life Sponsor Membership	$200.00
Sponsor Membership	30.00
Regular Membership	15.00
Associate Membership	5.00

Associate Membership is for medical students, interns, and residents.

If you are interested in becoming a member, or if you wish further information, please contact me.

A. M. GOTTLIEB, M.D.
President of APAA
3801 Miranda Avenue
Palo Alto, Calif. 94304.

New Indiana Law Pertaining To Blood as a Service

HOUSE ENROLLED ACT No. 1102

AN ACT to amend IC 1971, 29-2-15, concerning the gift by will or other written instrument, of whole or any part of the human body.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 1971, 29-2-15-1 (formerly Acts 1963, c. 196, s. 1) is amended to read as follows: Sec. 1. As used in this chapter unless otherwise provided the terms "bank" or "storage facility," "hospital," "physician" or "surgeon" shall have the same meaning as defined by IC 1971, 29-2-16-1.

SECTION 2. IC 1971, 29-2-15-2 (formerly Acts 1963, c. 196, s. 2) is amended to read as follows: Sec. 2. The procurement, processing, distribution or use of whole blood, plasma, blood products, blood derivatives, or other human tissue, such as corneas, bones or organs by a bank, storage facility or hospital and the injection, transfusion or transplantation of any of them into the human body by a hospital, physician or surgeon, whether or not any remuneration is paid is declared to be for all purposes the rendition of a service and not the sale of a product. No such services shall give rise to an implied warranty of merchantability or fitness for a particular purpose, nor give rise to strict liability in tort.

SECTION 3. IC 1971, 29-2-15 (formerly Acts 1963, c. 196) is amended by adding a new section to read as follows: Sec. 2.5. The Indiana State Board of Health shall establish reasonable standards for the procurement, processing and distribution of whole blood, plasma, blood products, or blood derivatives. In formulating such standards the Indiana State Board of Health shall consider present medical and scientific practices in the field and any other proper procedure that should be followed to reasonably insure the safety of the donor and recipient of whole blood, plasma, blood products and blood derivatives. Such standards shall be promulgated in the manner provided by law for the promulgation of rules and regulations of administrative bodies and may be rescinded, amended or modified in the same manner.

SECTION 4. IC 1971, 29-2-15-3 (formerly Acts 1963, c 196, s. 3) is specifically repealed.

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(diethylpropion hydrochloride, N.F.)

When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

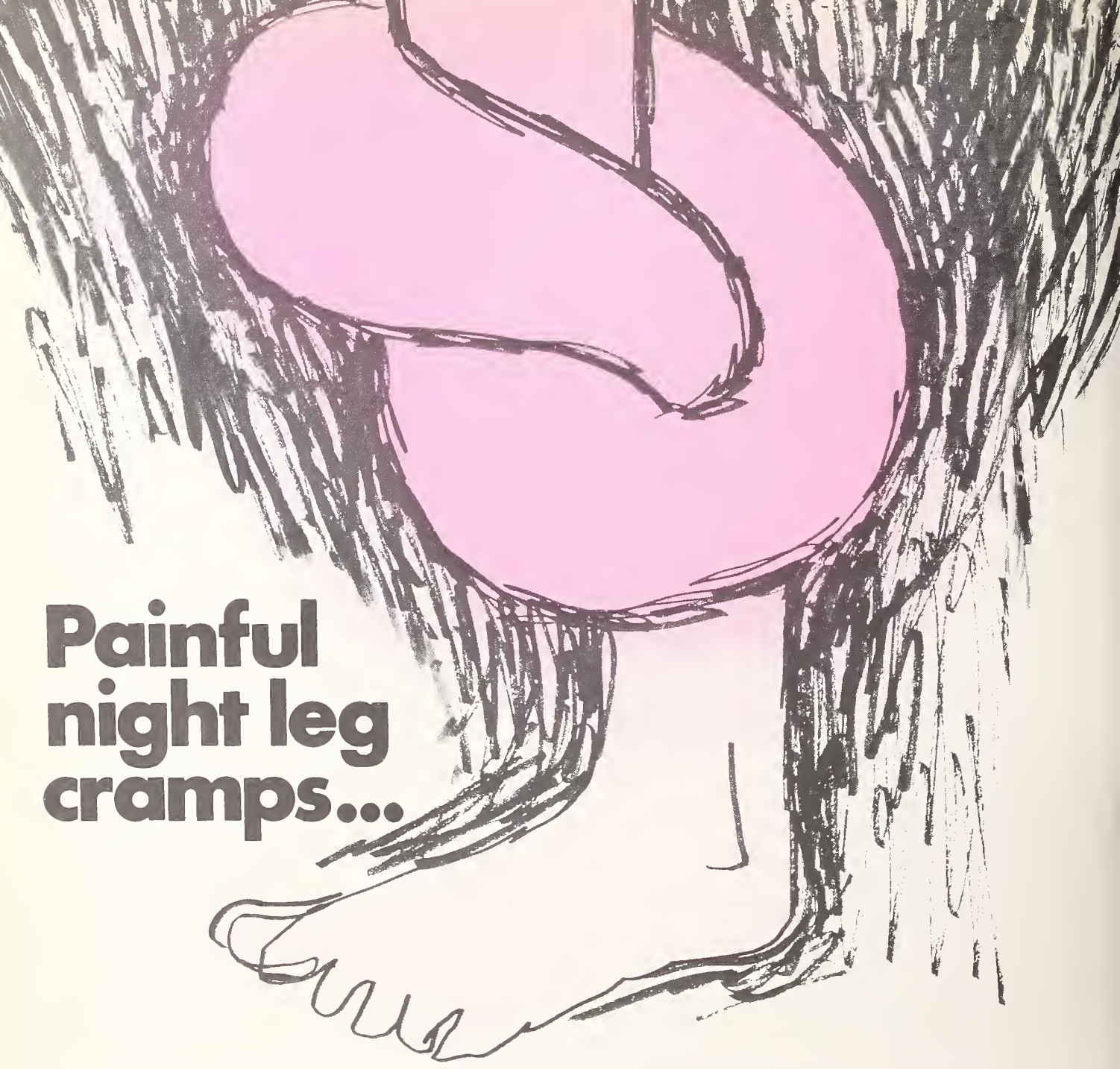
Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS *effects* such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic *cardiovascular effects* reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. *Allergic phenomena* reported include such conditions as rash, urticaria, ecchymosis, and erythema. *Gastrointestinal effects* such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

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unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastraintestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

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Specific therapy for night leg cramps

From *The Journal* 50 Years Ago

FROM all reports much may be expected from toxin-antitoxin injection in the production of permanent immunity to diphtheria. As has been pointed out by the recommendations of the Indiana State Board of Health, all children entering school for the first time should be immunized at once. Susceptibility to the disease may be determined by the Schick test.

———————————

THE surgeons are losing out. No longer can Crile, the Mayos and our own excellent Indiana surgeons operate goitres without fear of offending the real wise heads in the goitre curing game, for the chiropracs, according to their advertising, claim that they are curing goitre by "adjustments." . . .

———————————

POLIOMYELITIS is on the increase, there being many more cases in 1920 than during the previous year, and this year the number of cases is even still greater. The peculiar feature about the disease is that it appears in isolated cases and does not show any tendency to occur as an epidemic. . . .

———————————

AT present the United States has one doctor to 720 persons and Canada has one doctor to 1050 persons. Of course, this ratio is very much greater for the cities. In fact, all cities and towns in the United States have more doctors than are actually necessary. . . . Editorial Notes, *JISMA*, November 1921.

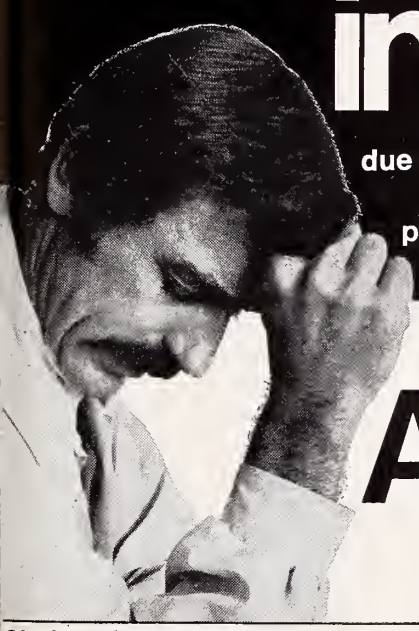
The treatment of

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due to androgenic deficiency in the American male.
The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

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T. Jakobovits
Fertility and Sterility, January 1970
Official Journal of the American Fertility Society



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Double-Blind Study and Type of Patient:
100 patients suffering from impotence. Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% on placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

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Dose: 1 tablet 3 times daily.
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Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

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Each orange tablet contains:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 or 2 tablets daily.
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Android-Plus
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Each white tablet contains:
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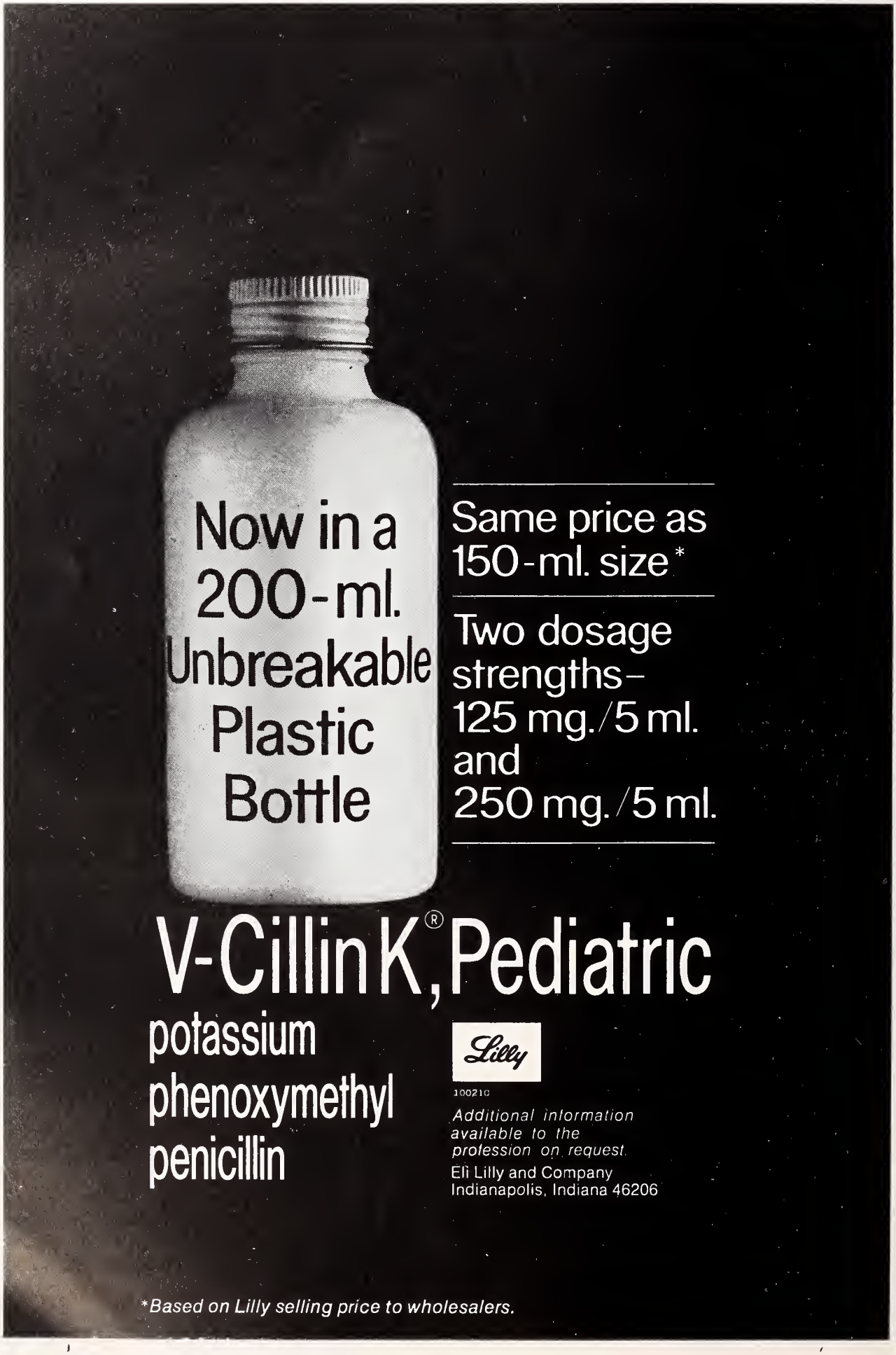
Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

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The Reporting of Venereal Disease by Physicians

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Indianapolis*



THE role of the physician begins with the diagnosis and treatment of the victim of venereal disease. But it cannot end there. For if these diseases are ever to be stamped out, it is imperative that every case be reported promptly to health authorities. It then becomes the responsibility of the health authority, with the approval of the reporting physician, to follow up on this report—to identify other persons who have had intimate contact during the course of infection. For these, too, must be located and examined and, if necessary, treated.

Reporting is one of the essential steps in the process of control and eradication. And yet we have faulted consistently in the past. A national survey of venereal disease morbidity was made of private physicians in 1968. In this survey, which covered April, May and June of that year, Indiana physicians indicated they reported only 15% of the primary and secondary syphilis they treated and only 10.1% of the gonorrhea treated. As a result, the follow-ups have not been and could not be effective.

The patient, of course, contributes much to create this state of affairs. Ashamed of or apathetic about his own infection, reluctant to embarrass or involve someone else by divulging names, he may request or insist on complete silence, even to the extent of not reporting through confidential medical channels. So long as the physician, under the cloak of doctor-patient relationship confidentiality, perpetuates this attitude and fails to report, nonreporting will remain as the great impediment to eradication.

Legally, it is the duty of every physician in the state of Indiana to report every person who comes under his examination and care and is found to have a venereal disease. This is in accord with state communicable disease regulations. In 1970 there were 530 practicing physicians in the State who complied with this regulation and reported one or more cases of venereal disease to the State Board of Health. There are about 5,700 licensed physicians in the state. Some of these will not see venereal disease because of their specialized work or practice, but how many others do not look for venereal disease or do not report it when they see it?

Many doctors do not fully trust the confidential nature of health de-

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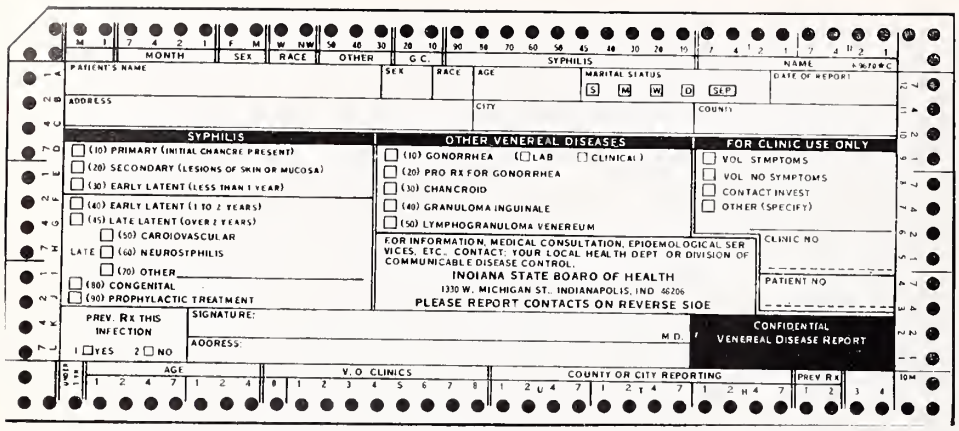


FIGURE 1

partment processing of venereal disease reports or do not fully understand the need for reporting as a basis of contact tracing. With regard to this, may it be emphasized that the physician makes his report on a special form (Figure 1) directly to the Division of Communicable Disease Control, Indiana State Board of Health. Other communicable diseases are reported to the local health officer who, in turn, reports to the State Board of Health.

On receipt of the report, a State Board of Health venereal disease epidemiologist will be assigned to the case. His first action is to obtain permission from the physician reporting the case to interview his patient regarding intimate contacts. Without this permission, he will not interview the patient. With permission, he will proceed with contact tracing in a most tactful and confidential manner, toward the objective of getting these contacts to medical examination. State regulations dictate that reports "shall be confidential and will not be disclosed except on court order, but may be utilized for statistical purposes without identification."

Surveys also indicate that those venereal disease cases that come to private medical attention are thinly distributed among a great many physicians. However, such cases in toto represent the great majority of treated infectious syphilis and gonorrhea incidence in the country in any given period. In this situation it is obvious how very important it is for each physician to report the occasional case coming to his attention, if any success in either control or eradication of venereal diseases is to be achieved. ◀

We are indebted to Alexander W. Cavins, M.D., Terre Haute, for the suggestion for the illustration on the preceding page and to Mrs. Miki W. Krause of Woodacre, Calif., for the drawing to illustrate the therapeutic history of syphilis.—**Ed.**

Spectinomycin for Acute Gonorrhea

FDA recently approved spectinomycin "Trobicin," (The Upjohn Company) for marketing. The drug is indicated only in the treatment of acute gonorrheal urethritis, proctitis, and cervicitis, when due to susceptible strains of *Neisseria gonorrhoeae*. This antibiotic, a product of *Streptomyces spectabilis*, is active against most strains of *N. gonorrhoeae* in a minimum inhibitory concentration varying between 7.5 and 20 mcg./ml. Cross resistance of *N. gonorrhoeae* between spectinomycin and penicillin has not been demonstrated.

Because of its high degree of efficacy and the long-term experience with penicillin, it is still considered the drug of choice for gonorrhea unless the organism is not sensitive to penicillin or the patient is allergic to penicillin. In addition, penicillin should be used when syphilis, suspected or confirmed, is concurrent with gonorrhea. Spectinomycin has no activity against syphilis. It should not be administered to children or during pregnancy.

Spectinomycin is administered only by intramuscular injection. It is rapidly absorbed. The antibiotic is not significantly bound to plasma protein. Spectinomycin can be administered safely to patients who are hypersensitive to penicillin.

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Dissection in a Congenital Aortic Sinus Aneurysm with Rupture into the Pericardial Cavity — A Case Report and Brief Review of the Literature

SHARIFULLAH NUMAN, M.D.
RICHARD H. CHILDRESS, M.D.
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Indianapolis*

Introduction

APPROXIMATELY 151 cases,[5,15-31] of congenital aneurysm of the sinus of Valsalva have been reported. The present report is unusual because it represents only the second instance of the combination of aortic sinus aneurysm, associated bicuspid aortic valve and death resulting from dissection in the aortic sinus with subsequent rupture into the pericardial cavity.

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This work was supported in part by the Postgraduate Cardiovascular Research Training Grant HE 05363 from the National Heart Institute.

Case Report

A 40-year old asymptomatic white male was first admitted to the hospital in 1966 for evaluation of a heart murmur. The past history revealed that the patient had been involved in automobile accidents in 1944 and 1963. The injuries suffered in the first accident were minor; however, the injuries of 1963 necessitated a craniotomy for treatment of a subdural hematoma. During that hospitalization, a systolic ejection murmur was heard but no other cardiac abnormalities were described. Following the 1963 accident, he had had occasional post-traumatic seizures but no other serious illnesses. He had been in the military service from 1951 to 1956 and had been told that he had a cardiac murmur but the exact details concerning its nature were unknown. The family history was unremarkable. Physical examination revealed a blood pressure of 115/70 mm Hg, a regular pulse rate of 96/min and no other abnormalities other than those related to the heart. The PMI was in the 4th ICS at the midclavicular line, a systolic ejection sound was present with a single accentuated second heart sound. A grade III/VI diastolic blowing murmur beginning with S_2 was noted at both the right and left sternal borders. The chest x-ray disclosed clear lung fields and slight cardiac enlargement with accentu-

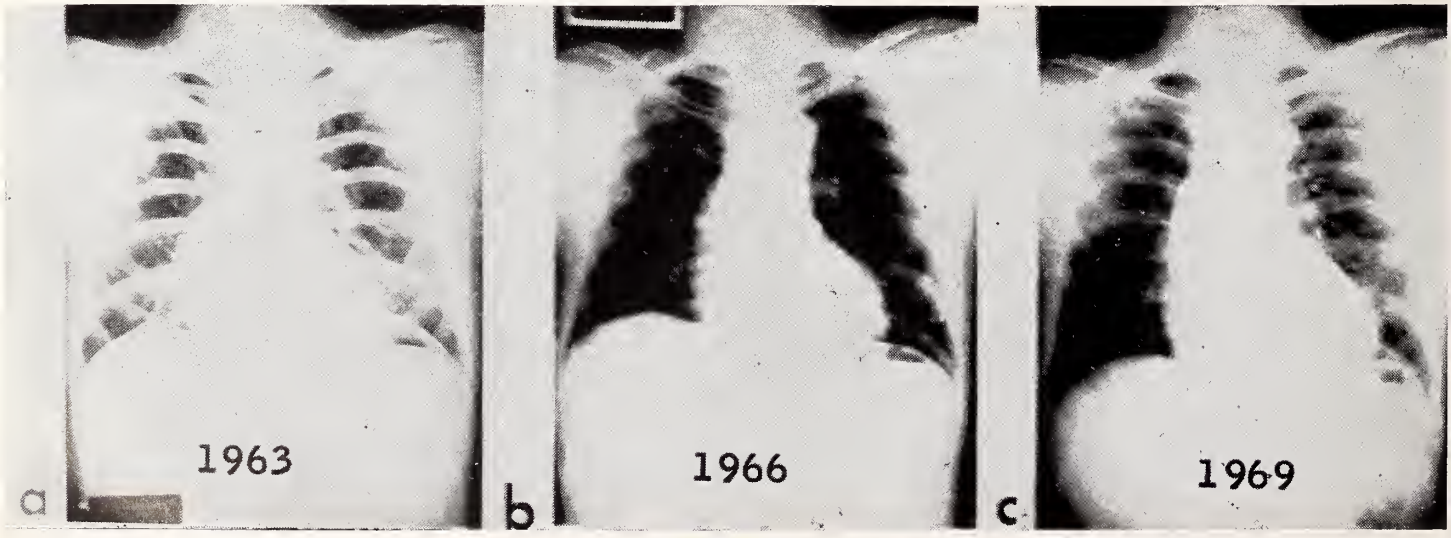


FIGURE 1
REPRESENTATIVE chest x-rays taken at the dates indicated.

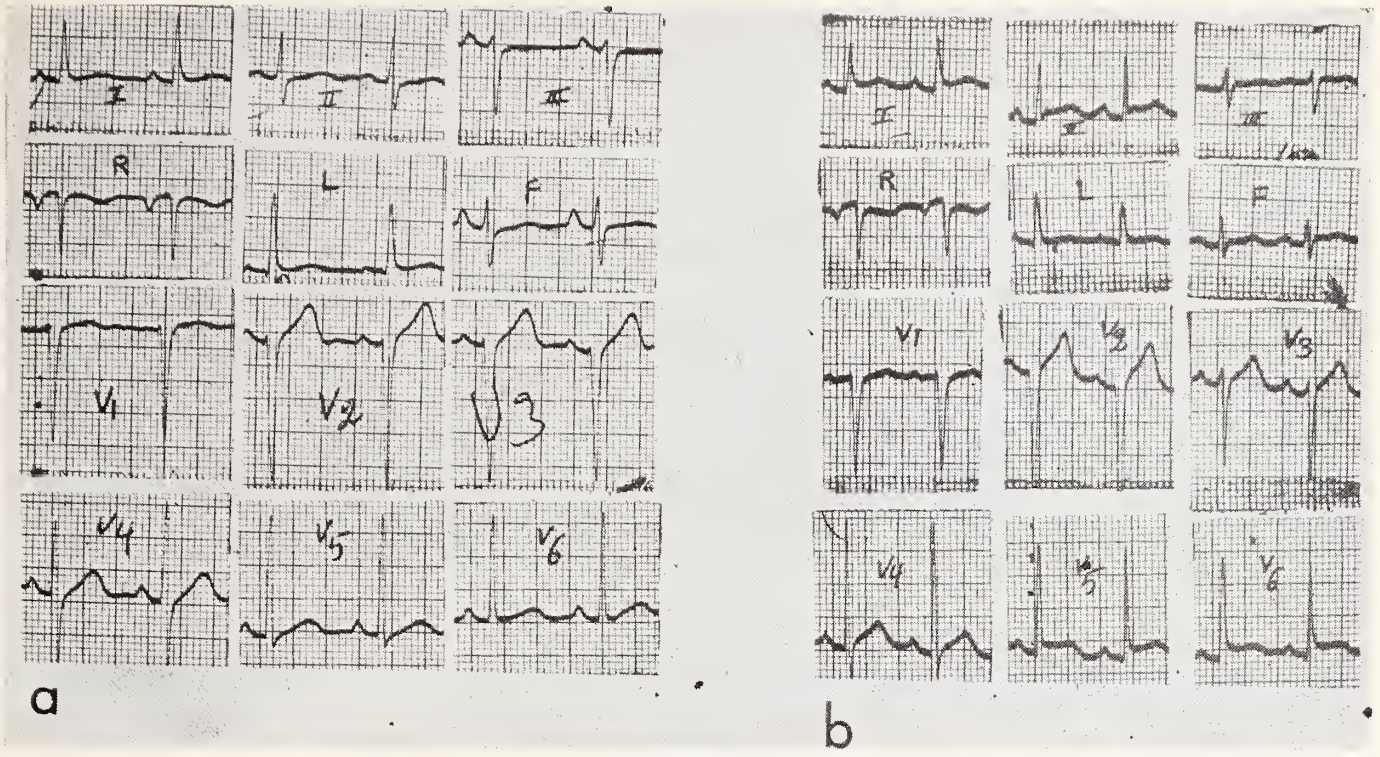


FIGURE 2
THE electrocardiograms taken in 1966 (a) and 1969 (b).

ation of the left ventricular component. The aorta was tortuous and ectatic (Figure 1b) as compared to that of 1963 (Figure 1a). Routine urine and blood examinations were within normal limits and the serology was negative.

The electrocardiogram revealed a moderate left axis deviation (Figure 2a). The patient underwent cardiac catheterization and the cineangiocardiographic study disclosed aneurysmal dilatation of two aortic sinuses as well as moderate aortic insufficiency (Figure 3). The cines were reviewed by Dr. I. Steinberg (see Discussion). The patient was discharged with the diagnoses of congenital aortic sinus aneurysms, aortic insufficiency and post traumatic seizures and was followed as an out-

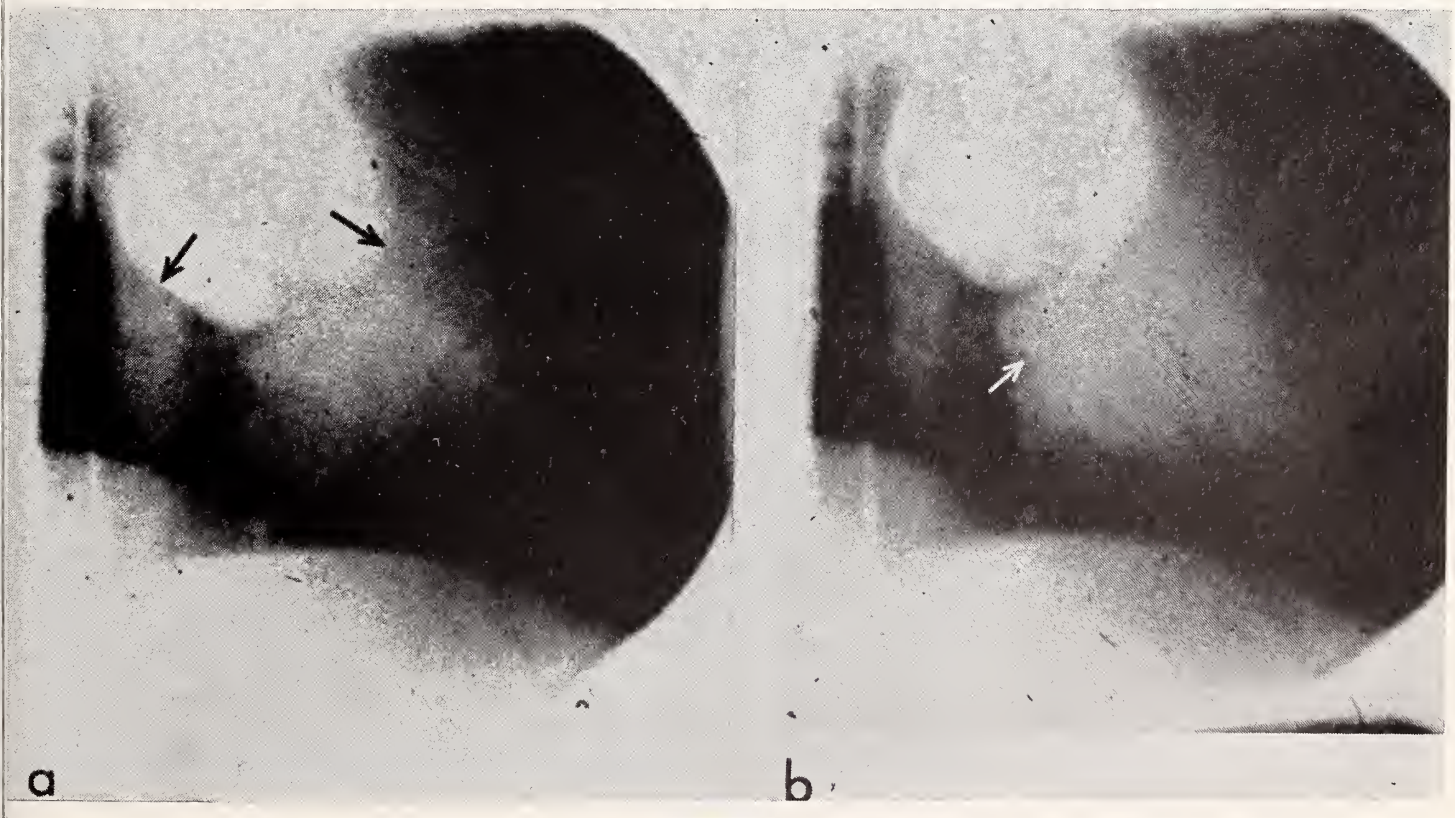


FIGURE 3
(a) CINE frame of supravalvular aortic injection revealing the two aortic sinus aneurysms.
(b) An additional frame better demonstrating the regurgitant stream of aortic insufficiency.

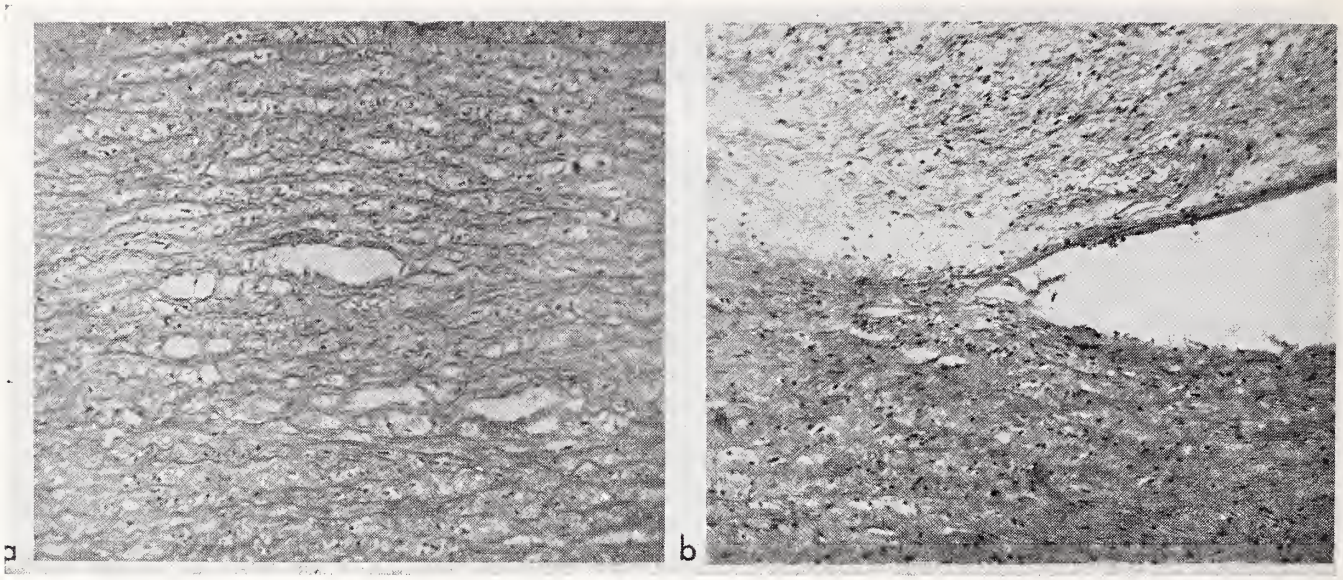


FIGURE 4

MICROSCOPIC section (X430)
(a) Section through the proximal aorta showing cystic medial necrosis.
(b) Section demonstrating the plane of cleavage of dissection of the aortic media.

patient except for a short admission to the Neurology Service for seizure control in 1967.

In November 1969, the patient was readmitted for a low grade fever, malaise and bilateral anterior chest discomfort. The pertinent physical findings included a blood pressure of 108/60 mm Hg, a regular pulse rate of 110/min and a respiration rate of 20/min. The temperature was 102° F orally. Examination of the heart revealed no gross change from that described in 1966. The remainder of the physical exam was unremarkable.

The chest x-ray again showed minimal cardiomegaly with prominence of the ascending aorta (Figure 1c). The electrocardiogram revealed ST segment elevation in leads I, II, V_5 and V_6 consistent with pericarditis (Figure 2b). Other laboratory studies, including blood cultures, were negative.

On the second day of hospitalization, he was noted by fellow patients to have suddenly fallen from a sitting to supine position in his bed and to have developed gasping respirations. Cardiac resuscitation was unsuccessful.

Post Mortem Examination

The pericardial space was distended with 700 cc of both clotted and unclotted blood. Cardiac enlargement (500 gm) was present and was primarily due to increased left ventricular size. The other gross abnormalities were limited to the ascending aorta, aortic valve cusps and aortic sinuses. The valve was bicuspid and the anterior leaflet was deformed and calcified to a moderate degree. Both aortic sinuses were aneurysmal with the posterior being 5 cm in depth. A horizontal tear of the aorta approximately 2 cm above the commissures and involving about one half the circumference of the posterior sinus was found. The aortic wall was dissected superiorly 5 cm and inferiorly 2 cm from the tear. Although several hemorrhagic foci were found in the outer wall of the aorta, no distinct communication was found with the pericardial space. Both coronary arteries originated from the anterior sinus and were normal to inspection. Unfortunately, although photographs of the gross findings were obtained, they have been misplaced and lost. The microscopic examination revealed changes as described in Figure 4. Further studies of the aortic root and the other aortic sinus aneurysm revealed changes consistent with cystic medial necrosis.

Discussion

The mechanism of development of congenital aortic sinus aneurysms is unknown. However the anatomic defect of the aortic media is thought to be present at birth.[7] Several reports suggest that the aneurysmal dilatation itself develops over a long period of time[8] and this is supported by the observation that the average patient age at the time of serious complications and/or death is in the fourth decade of life.[6] The precise anatomic defect has been described in detail by Edwards who showed that there was a lack of fusion of the aortic wall media with the annulus fibrosis of the aortic valve.

Aortic sinus aneurysms may be either congenital or acquired. The congenital variety should be ruled out by looking for the clinical stigmata of Marfan's Syndrome, Ehlers-Danlos Syndrome, osteogenesis imperfecta, coarctation of the aorta or cystic medial necrosis of Erdheim, all of which have been reported as associated with aneurysms of the aortic sinuses. On the other hand, aortic sinus aneurysms of the acquired type may be associated with bacterial endocarditis, lues, trauma, rheumatoid disease or dissection of the aorta associated with hypertension.

The physical examination in the patient with a congenital unruptured aortic sinus aneurysm is usually unrewarding because of the frequency of associated cardiac defects such as ventricular septal defect, patent ductus arteriosus and coarctation of the aorta. In the absence of other lesions, a systolic ejection murmur is commonly present and the murmur of aortic insufficiency has been reported on several occasions. The latter has been thought due to aortic leaflet lesions in some and to aortic annulus deformity produced by the sinus aneurysm in others.[9,10,12,15,16] In the current case, the anterior cusp deformity is suspected as being most likely responsible for the aortic insufficiency.

The electrocardiogram is usually normal in patients with unruptured aortic sinus aneurysm. In the currently reported case, the electrocardiographic changes combined with the history raised the suspicion of a viral pericarditis at the time the record was obtained (Figure 2b). In retrospect, the changes were due to the hemorrhagic pericarditis produced by the dissection of blood into the pericardial sac.

The definitive diagnosis of unruptured aneurysm of the aortic sinus is dependent on retrograde aortography. However, 2-meter chest x-rays and fluoroscopy may be helpful if they show a pulsatile noncalcified mass in the area of the aortic root. In the case reported, since the etiology of the aortic insufficiency was obscure and since there had been a significant change in the routine chest films from 1963 to 1966, cardiac catheterization and retrograde aortography were performed. The cines were reviewed by Dr. Israel Steinberg, who confirmed that the supravalvular aortic injection (Figure 3) showed moderate aortic insufficiency as well as demonstrating aneurysmal dilatation of the anatomic areas corresponding to the right and left aortic sinuses. It was Dr. Steinberg's impression that the aneurysms might be due to either a variant of Marfan's Syndrome or idiopathic cystic medial necrosis. Dr. Steinberg suggested that biplane angiograms might reveal linear streaks, which would indicate a tear within the aorta, which would indirectly suggest a dissection of the aorta. However, such a study was not technically possible at the time. When a congenital aortic sinus aneurysm is suspected, a complete catheterization study should, of course, include measures to exclude associated anomalies.

Table 1 summarizes the incidence and some of the details concerning rupture of congenital aortic sinus aneurysms. The usual complications are rupture with fistula formation, subacute bacterial endocarditis and congestive heart failure.[9,13] Of a total of approximately 154 patients with congenital aortic sinus aneurysms, 87 are reported to have ruptured but in only 67 patients (72 aortic sinuses) are the origin and rupture site clearly identified. Fifty ruptures originated from the right coronary sinus, 19 from the noncoronary sinus and the remaining three from the left coronary sinus. The most common sites of rupture are the right atrium and right ventricle and clinically signs and symptoms of acute right heart failure dominate.

Walcher's case is similar to the present case in that both a bicuspid aortic valve and dissection with rupture into the pericardial cavity with fatal tamponade are described. However in his case, the dissection originated in the right coronary sinus, only one coronary artery was present and aortic insufficiency was not reported.

There have been numerous reports of successful surgical treatment of congenital aortic sinus aneurysms which ruptured into the right heart. Following rupture in this location, surgical management should be ser-

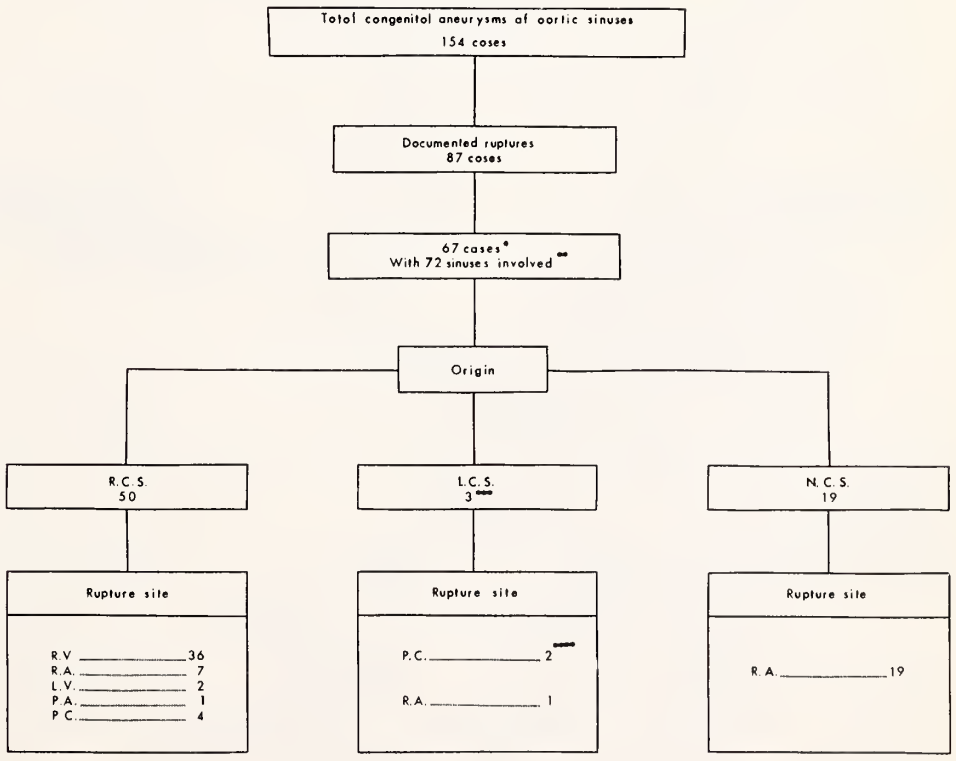


TABLE 1

DIAGRAMMATIC representation of reported congenital aortic sinus aneurysms with location of rupture origin and termination.

iously considered as soon as the clinical condition permits.

There have been six reports of dissection in the aortic sinus with rupture into the pericardial cavity, and surgery has not been attempted in any. The precipitous death of these patients, including the current case, after rupture would seem to preclude consideration of surgical intervention both because of the rapidity of clinical deterioration and the difficulty in surgical management at this location. The experience with these patients and the shortened average life span of patients with unruptured aortic sinus aneurysms in general makes one wonder whether surgical correction should be considered in any patient in whom the diagnosis can be made prior to dissection and rupture.

Summary

A 40-year old man with congenital aortic sinus aneurysms, a bicuspid aortic valve and dissection in the left coronary sinus aneurysm with rupture into the pericardial cavity is reported. The etiology, pertinent diagnostic considerations and therapy are discussed, together with a brief review of the literature.

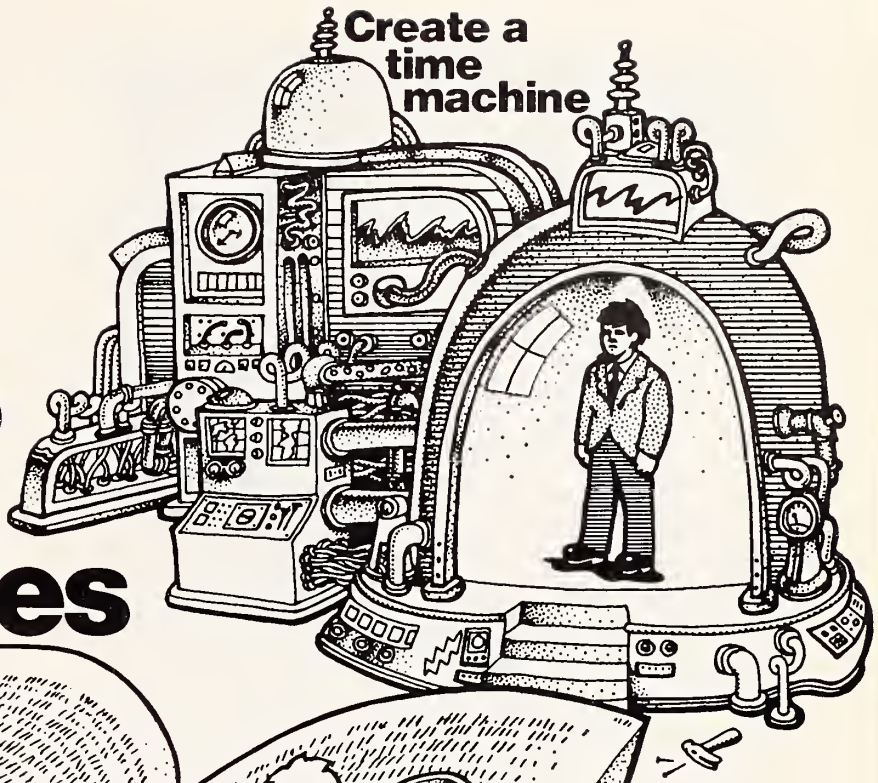
Acknowledgment

The authors express their appreciation to Dr. Israel Steinberg for his interpretation and comments concerning the angiograms.

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F19A73

Management of Tracheal Stenosis Secondary to Prolonged Ventilation Utilizing a Cuffed Tracheostomy Tube — A Case Report

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Marion*

Introduction

SINCE the advent of cuffed tracheostomy tubes, many lives have been saved by the continuous ventilation of the patient suffering from the crushed chest syndrome. However, as a result of the almost continuous outward pressure focused on a small segment of the trachea, local necrosis of the tracheal wall has been observed. As a result, this necrotic area loses its elastic structure, causing near collapse of that segment, with resultant respiratory distress.

This is a case report of one such occurrence.

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History

On 8-31-69 a 35-year-old white female was admitted to the Marion General Hospital, Marion, Ind., in a critical state due to crush injuries to the rib cage and left clavicle, resulting in bilateral pneumothorax, left hemothorax and flail chest (See Figure 1). She was treated immediately with a tracheostomy and bilateral tube thoracostomies. Within 48 hours her respiratory status worsened. The metal tracheostomy tube was removed and a cuffed

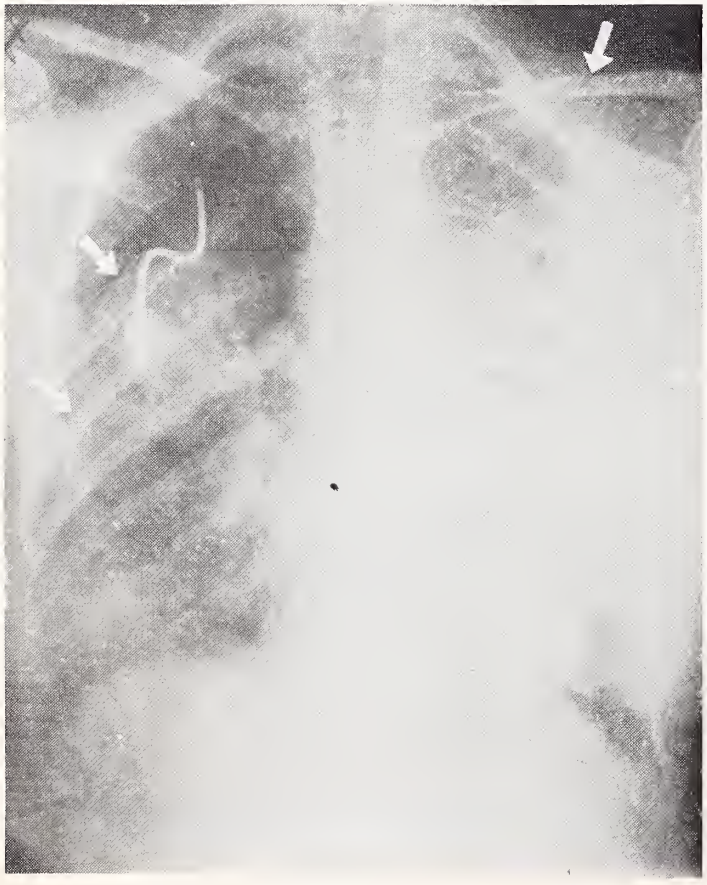


FIGURE 1

PORTABLE AP chest taken shortly after the accident showing bilateral pneumothorax, left hemothorax, pulmonary contusion and multiple fractures.

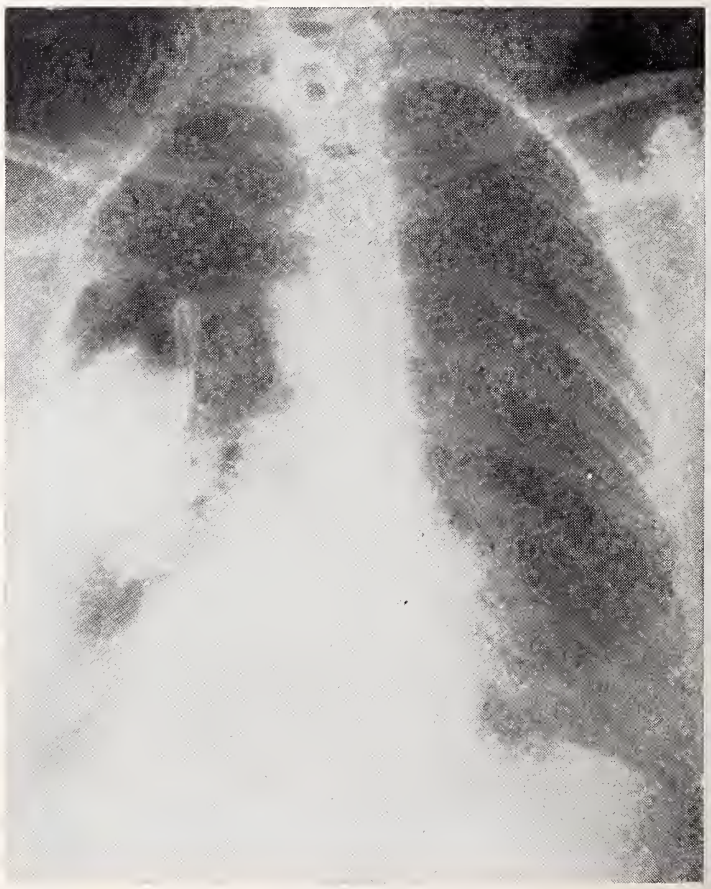


FIGURE 2

PORTABLE AP chest showing hemorrhage around the left chest tube.

Portex plastic tracheostomy tube inserted, the cuff inflated, and a long siege of artificial ventilation with the Bennett MA-I ventilator began. Over the next four weeks, she suffered numerous setbacks in the form of hemorrhage throughout the left chest tube and a resultant left bronchocutaneous fistula, pneumonia and partial atelectasis (See Figures 2 and 3). An attempt was made to wean the patient from the ventilator. During the four-week period of ventilation, strict sterile technique was utilized in the care of tracheostomy and the cuff was deflated every half hour for five minutes.

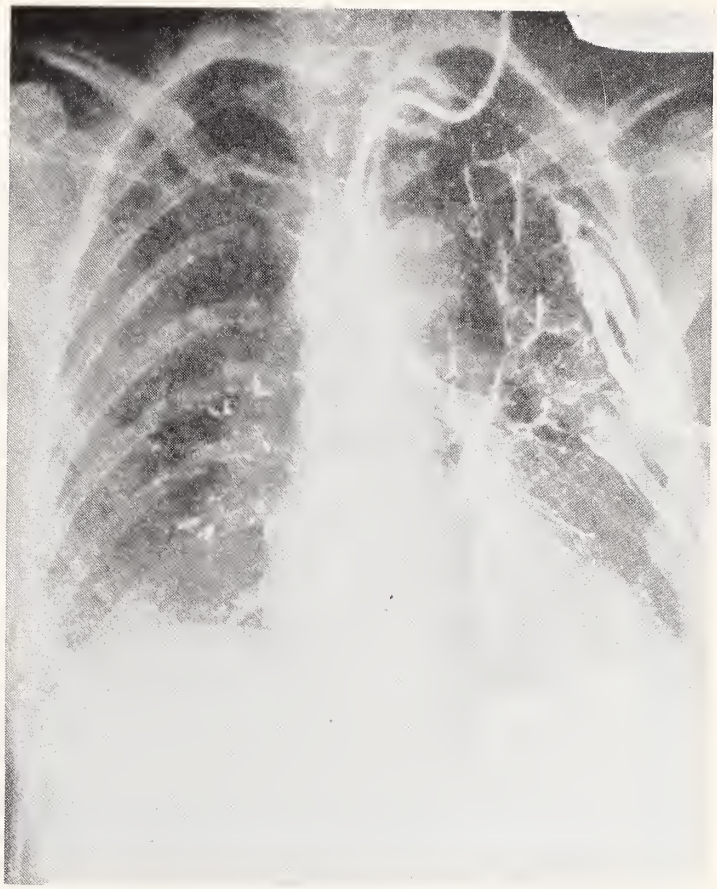


FIGURE 3
SELECTIVE left bronchogram showing bronchocutaneous fistula along left chest tube.

During this five-minute period of cuff deflation, ventilation was maintained by vigorous use of the Ambu Bag. She continued to progress satisfactorily and was successfully weaned from the ventilator and the tracheostomy tube was removed at six weeks post-injury. Two weeks later, while still in the hospital, she suffered a sudden onset of asthmatic-like symptoms and a tracheal stenosis was suspected. She was then taken to surgery, where a tracheoscopy under topical anesthesia revealed a stenosis of the trachea and granulation tissue formation approximately 2 cm below the tracheal stoma. The patient was then deeply anesthetized with ether anesthesia and then decannulated, breathing spontaneously. With the use of the ventilating bronchoscope, respirations were assisted and curettage was carefully performed intermittently with the ventilation. The patient was intubated with a cuffed nasotracheal tube and transferred to the intensive care unit for 24 hours of gentle assisted respiration and then extubated. A #5 metal uncuffed tracheostomy tube was inserted, but she still experienced some respiratory difficulty due to collapse of the trachea at the site proximal to the end of the tube, at the old cuff site. A tracheogram was done revealing a stricture which collapsed on expiration (See Figure 4). The remainder of the trachea was normal.

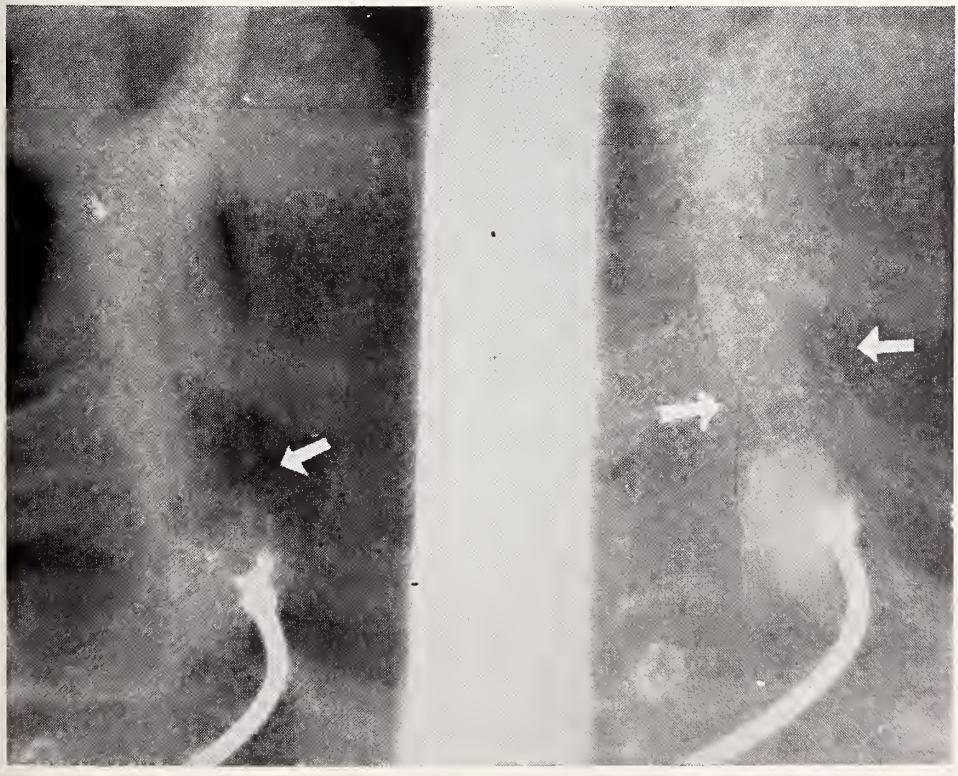


FIGURE 4
TRACHEOGRAM showing area of narrowing and irregularity. A. Inspiration, B. Expiration.

At this point, it became obvious that tracheomalacia was indeed the problem and that resection of the diseased segment was necessary.

At this time, with the metal tracheostomy tube in place, she was unable to talk, indicating collapse of the trachea around the metal tube. Upon removal of the metal tube, she was able to breathe and to talk with

some slight difficulty. However, any exertion or coughing spells, while the tube was out, resulted in dyspnea and extreme apprehension. She was then furloughed home with the metal tube in place for two weeks, prior to her return for definitive surgery.

Anesthetic Procedure

Following 24 hours of intermittent positive pressure breathing for bronchial toilet, anesthesia was established by utilizing the metal uncuffed tracheostomy tube and an anesthetic mixture of 50-50 nitrous oxide followed by gradual introduction and increasing concentration of Halothane. At no time was the patient allowed to cease spontaneous ventilation. Upon establishing surgical anesthesia, the cords were exposed and cocainized intermittently over a period of some five minutes.

Then, carefully removing the tracheostomy tube, she was intubated orally with a Portex plastic cuffed oral tracheal tube. It was noted upon insertion of this tube with the patient breathing that a #7 adult tube would not pass the area of stenosis on exhalation. However, with inspiration, the tracheal walls were open sufficiently to allow passage of the tube.

Operation

The patient's neck was hyperextended. A transverse neck incision was made, elliptically excising the tracheotomy wound and its granulation tissue. The trachea was exposed. By blunt dissection, the substernal space was developed and a T-shaped extension of the wound was made. The manubrium was divided to the second left intercostal space. The tissues were dissected off the anterior wall of the trachea from the cricoid cartilage down to the bifurcation of the trachea. The area of stenosis was identified 2½ cm below the tracheostomy opening in the trachea. The stenosed area of trachea was mobilized by blunt and sharp dissection. A Levin tube was passed down the esophagus in order to help delineate the esophagus from the trachea. There was considerable scarring in this area.

The posterior wall of the trachea was also mobilized by blunt and sharp dissection from the cricoid cartilage down to the bifurcation of the trachea. Extreme care was taken to preserve the lateral fascial and vascular attachments to the trachea in order to preserve its blood supply. A longitudinal incision was made across the anterior stenotic area of the trachea to allow internal inspection. On examination the inner wall of the trachea contained a considerable amount of granulation tissue. The tracheal rings in this area had been destroyed. Approximately 2 cm of trachea was excised circumferentially around the indwelling endotracheal tube. The inflated cuff of the endotracheal tube was just distal to the distal line of transection of the trachea.

Several 3-0 Mersilene sutures were placed through the open ends of the trachea behind the endotracheal tube. Lateral traction sutures were placed adjacent to the distal and proximal ends of the trachea. These traction sutures were pulled in opposite directions to approximate the trachea while the posterior sutures were tied. The neck was flexed to allow for easier anastomosis. The endotracheal tube was slowly withdrawn proximal to the line of anastomosis to allow careful inspection of the posterior suture line. It is extremely important that this suture line be airtight. When it was seen that the posterior suture line was satisfactory, the tube was carefully reinserted into the distal trachea and the cuff was reinflated. The anastomosis was completed with 3-0 Mersilene sutures across the anterior trachea. Knots were tied on the outside of the trachea. The tracheostomy opening in the trachea was cleansed of scar tissue and granulation tissue, and was closed with interrupted 2-0 chromic catgut sutures. All suture lines were tested for air leaks with normal saline by withdrawing the endotracheal tube to a point proximal to the suture line and applying gentle positive pressure through the cuffed tube. There were no identifiable air leaks. Hemovac drains were then placed into the mediastinum. The sternotomy incision was closed with 2-0 Flexon Wire, subcutaneous tissues were approximated with 4-0 chromic catgut and the skin was closed with 5-0 nylon sutures.

The patient was moved to the intensive care unit where she was extubated. We did not keep her intubated after she regained consciousness and did not use a tracheotomy tube postoperatively. She awoke slowly in the intensive care unit, breathing easily and conversing freely.

Postoperative Course

She was followed closely in the intensive care unit. She was given intermittent positive pressure breathing treatments gently and with very low pressure. She developed only one short period of temperature elevation which subsided with antibiotic therapy.

She was discharged to her home approximately two weeks after surgery without respiratory difficulty. She did develop a mild wound infection in the subcutaneous tissues of the sternotomy wound. This required removal of the Flexon Wire sutures in the office under local infiltration anesthesia. She kept her head flexed for several weeks after surgery because of the shortened trachea and because of muscle spasm.

During her convalescence in the hospital, her head was maintained in approximately 20° to 35° flexion for comfort. However, after about three months she regained almost complete range of neck motion. Five months after her surgery she returned to her work as a Licensed Practical Nurse. She made an excellent recovery.

Discussion

The use of the relatively new cuffed tracheostomy tubes has been a life-saving measure in many patients with the crushed chest syndrome. This case, however, illustrates a life-threatening complication which may develop from the use of these cuffed tubes. Pressure from the inflated cuff against the trachea interferes with the circulation in the tracheal wall. This, coupled with infection, causes necrosis of the cartilaginous rings of the trachea and necrosis of the mucous membrane. This results in the formation of granulation tissue and scar. The tracheal wall collapses and produces respiratory obstruction. This condition, when first seen, mimics an asthmatic attack because the patient has difficulty with expiration and an expiratory stridor is produced. With normal inspiration the trachea lengthens, and with expiration the trachea shortens. Thus, the unsupported area of tracheomalacia collapses on expiration producing a partial or complete obstruction. It is pulled open in inspiration as the trachea lengthens. This is, in essence, an accordion effect. This was vividly demonstrated by direct visualization through a bronchoscope and by cineradiography.

The onset of obstructive symptoms from tracheomalacia is apparently two to three weeks following the removal of the cuffed tube. Therefore, it is important to closely observe these patients for several weeks after removal of a cuffed endotracheal tube or tracheotomy tube. It should be kept in mind that the involved area is 2 to 2½ cm below the tracheotomy opening. Because of this fact, when a tracheotomy is made for use of a cuffed tube, the tracheal opening should be made in the upper trachea. This will facilitate resection of the trachea if stenosis or tracheomalacia should develop. One could probably resect a high stenosis without doing a sternotomy. This case required extensive mediastinal dissection because the tracheotomy was made low in the neck.

One can expect infection in the operative wound because of the fact that a tracheotomy wound is always infected with Staphylococci and other oral and cutaneous bacteria. For this reason, all wounds should be adequately drained and closed loosely. The tracheal anastomosis should be airtight. During the first two weeks after resection of the trachea, the neck should be left flexed about 15° to 30° to prevent undue tension on the anastomosis; after three weeks, active exercise of the neck may begin.

From our experience with this necrosis, we feel this is not an extremely difficult surgical exercise and that this problem can be managed in any well staffed general hospital.

There are apparently many variations of stenosis and respiratory distress caused by tracheomalacia. Many of these patients are asymptomatic and, of course, do not require specific treatment. However, those who do develop respiratory distress with or without exertion will probably benefit from a resection of the sternal trachea with an end-to-end anastomosis.

Acknowledgments

Acknowledgment is given to Everett Smith, M.D., and Robert L. Stephenson, R. T., X-Ray Department, Marion General Hospital, Marion, Ind., for preparing the photographs for this article.

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Erratum

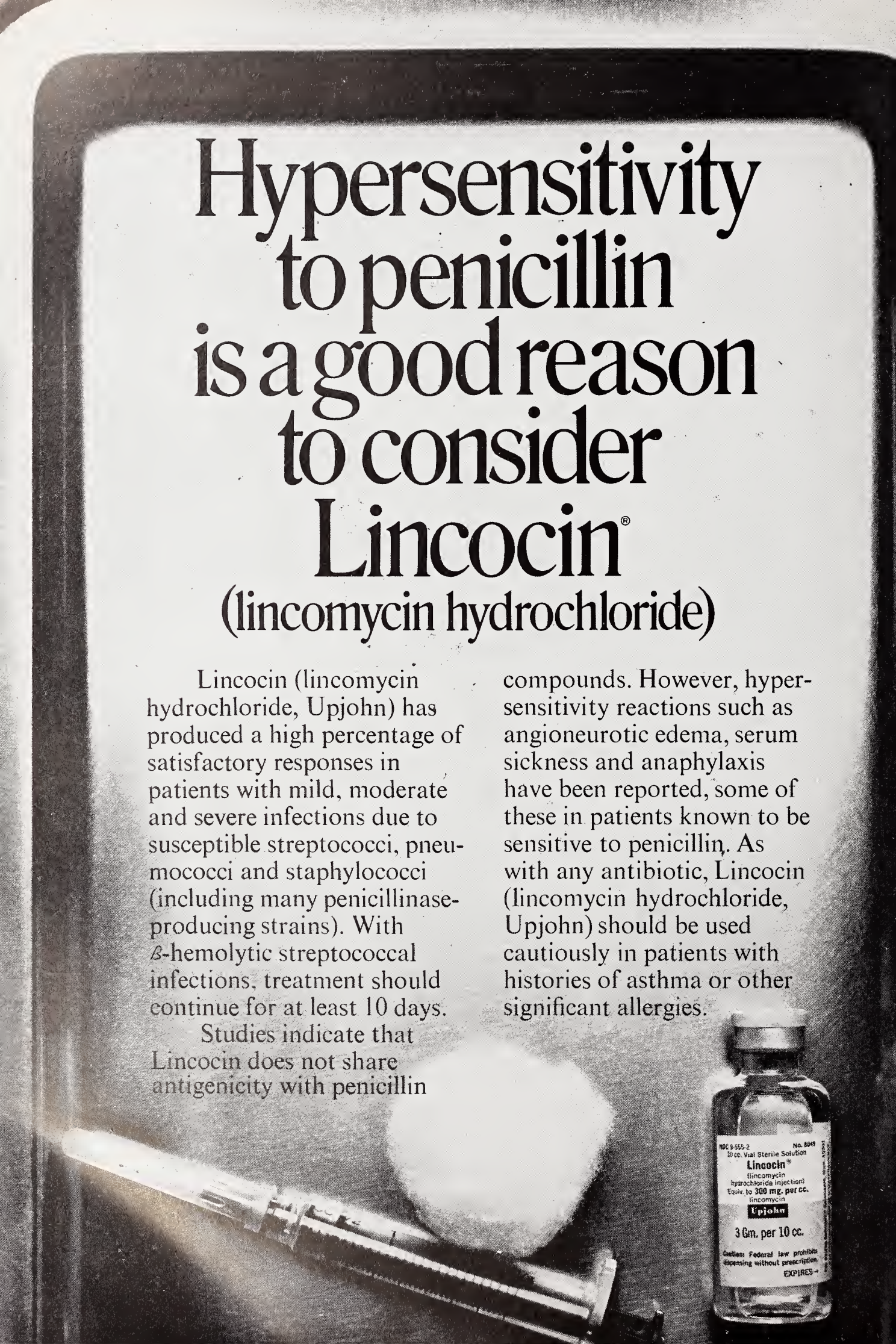
A statement that the study reported in "Effect of Certain Neonatal Practices on Serum Bilirubin of the Normal Newborn," *JISMA*, April 1971, was supported in part by Grant No. 5T01GM00024-13, National Institutes of Health, was inadvertently omitted from the article.

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So is penicillin-resistant staph.

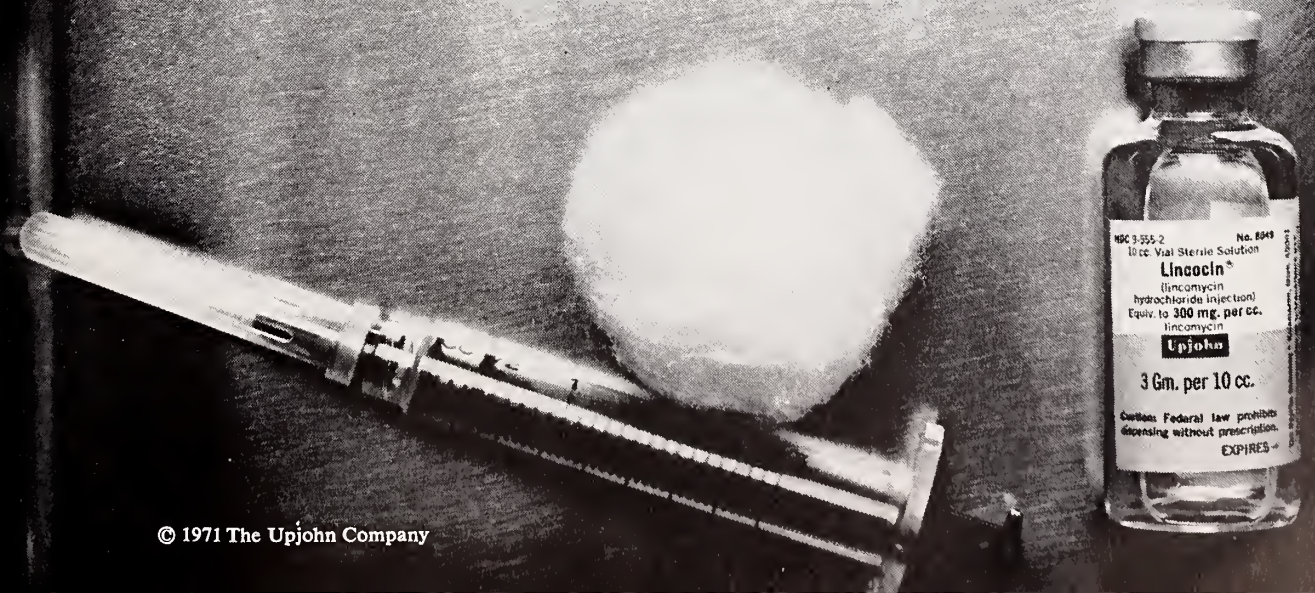
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PRECAUTIONS: Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of β-hemolytic streptococci infection for ten days to diminish likelihood of rheumatic fever or glomerulonephritis.

ADVERSE REACTIONS: *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatment. *Skin and mucous membranes*—Skin rashes, urticaria, vaginitis, and rare instances of exfoliative and vesiculobullous dermatitis have been reported. *Liver*—Although no direct relationship to liver dysfunction is established, jaundice and abnormal liver function tests (particularly serum transaminase) have been observed in a few instances.



Cardiovascular—Instances of hypotension following parenteral administration have been reported, particularly after too rapid I.V. administration. Rare instances of cardiopulmonary arrest have been reported after too rapid I.V. administration. If 4.0 grams or more administered I.V., dilute in 500 ml. of fluid and administer no faster than 100 ml. per hour. *Local reactions*—Excellent local tolerance demonstrated to intramuscularly administered Lincocin. Reports of pain following injection have been infrequent. Intravenous administration of Lincocin in 250 to 500 ml. of 5% glucose in distilled water or normal saline has produced no local irritation or phlebitis.

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Treatment of Fractures of the Os Calcis

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Introduction

FRACTURES involving the os calcis frequently present complex problems in treatment. One explanation for this is that there are many varieties of heel bone fractures and with these the degree of severity of damage to the os calcis and subtalar joint varies. The more simple fractures, such as the "beak" fracture of the superior margin of the posterior half of the body of the os calcis, as well as uncomplicated fractures of the sustentaculum tali, are not difficult to manage by simple principles of treatment, but these constitute only a small proportion of all calcaneal fractures.

These fractures result in serious and prolonged disability. Permanent disability of a high degree is inherent in the fracture since it is an injury of the essential weight-bearing structures of the foot. Normal anatomy of bone, joints and soft tissues of the heel are disrupted and may result in painful dysfunction of the weight-bearing structures. Although some aspects of fracture treatment are generally accepted, standard routine care of the fractures is not a matter of common agreement, as evidenced in the discussion to follow.

Statistics made available by state industrial commissions, independent surgeons and insurance companies indicate that fractures of the calcaneus account for something less than two percent of all fractures. The initial period of incapacitation parallels the severity of the fracture, except in bilateral fractures where it is disproportionately long. Disregarding bilateral cases, the duration of primary disability was about six and one-half months. On further evaluation of the reports it appears that seven percent of all fractures did not involve the subtalar joint, whereas in the remaining 93% subtalar involvement was present and in these latter cases there was some loss of lateral motion and persistent pain of variable intensity. Thus, in 13 of 14 fractures of the os calcis there will be a degree of partial disability of the foot which will vary from 10 to 90%, with the average being 20%.

Anatomy

The os calcis is the largest of the tarsal bones and lies beneath the talus and supports it. The posterior talar articular surface is on the upper surface about the middle of the bone. Anterior to this is the sulcus calcanei, which helps to form the canal portion of the sinus tarsi (Figure A). An-

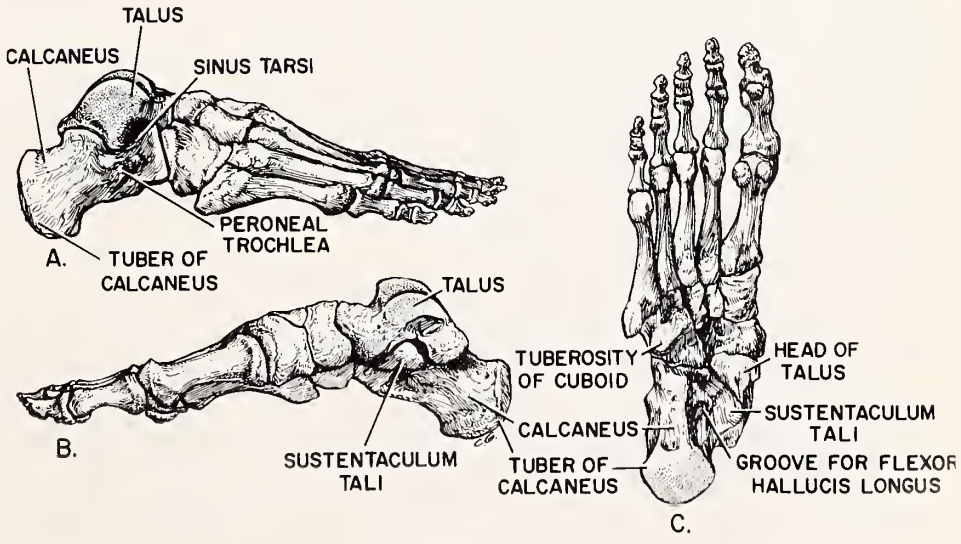


FIGURE A, B, C

* From the orthopedic service, St. Vincent Hospital, Indianapolis.

terior to this, on the upper surface of the medial projecting sustentaculum tali, is the middle talar articular surface and most anterior is the anterior talar articular surface, sometimes continuous with the middle one. The anterior end of the bone forms the cuboid articular surface (Figure B).

The downward projection of the back end of the inferior surface is the tuber calcaneus. It carries the rounded medial and lateral tuberal processes which support the weight put on the heel (Figures B and C).

The subtalar joint lies between the posterior calcaneal articular facet on the body of the talus and the posterior facet, but physiologically and clinically one includes the anterior articulation as part of the talocalcaneonavicular joint, between the middle and anterior facets on the inferior surface of the talar head and corresponding surfaces on the os calcis. The other articulation of the os calcis is the calcaneocuboid joint. The cuboid articulates with the anterior facet of the os calcis.

Weight Distribution

In quiet standing, approximately half the weight on the limb is said to be borne by the os calcis and half on the heads of the metatarsals in a proportion of 2:1:1:1, counting from digits one to five. This can change by a slight change in the position of the foot and the direction in which the weight is loaded. In walking, where the weight is shifted progressively from the heel to the ball of the foot, the line along which the weight falls is a straight one, which tends to be parallel with the line of progression. Thus, if one toes slightly out, weight is first borne primarily on the lateral side of the heel and then shifted forward in a straight line through the head of the first metatarsal. If, however, one toes slightly in, the maximal weight is first borne by the inner side of the heel and then shifted forward to the lateral side of the foot.



FIGURE D

X-ray Technique

Close cooperation between the surgeon and the radiologist is essential in determining the exact nature of the fracture of the os calcis and separating those where conservative treatment is indicated as opposed to a surgical approach.

X-rays of a suspected fracture of an os calcis should include three views: axial, lateral and Anthonsen oblique views.

To obtain an axial view, a towel is placed around the forefoot and the patient pulls on it, dorsiflexing the foot. The x-ray is then taken with a downward oblique shot. The resulting radiograph should demonstrate clearly the subtalar joint (Figure D).

The lateral view is self-explanatory.

Anthonsen's oblique view is taken again with the foot dorsiflexed and placed in a lateral position on the cassette and the x-ray is directed to a point just below the medial malleolus with angulation of 25° toward the foot of the table and 30° toward the toes (dorsi-ventral). The ray strikes the posterior articular facet tangentially and passes in the direction of the long axis of the sulcus calcanei. These x-rays will help delineate whether there is subtalar joint involvement and thus aid in determining treatment and prognosis.

Mechanism of Injury

Fractures of the os calcis occur most frequently in civilian life as a result of a fall from a height, landing on the feet on a hard surface. To understand the mechanism of injury, it is probably simplest to regard each fracture of the os calcis as a fracture

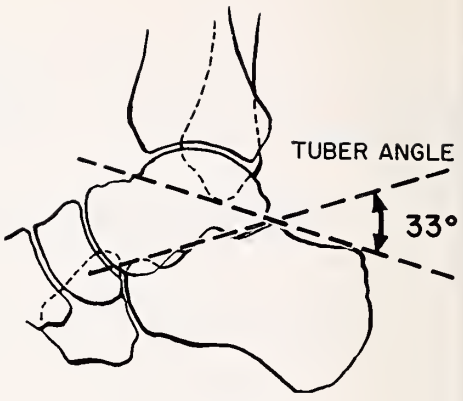


FIGURE E

with or without subtalar involvement produced by one or a combination of the following three types of fractures: 1. Avulsion, 2. Compression, 3. Shearing.

Shearing fractures with subtalar joint involvement are produced by the simultaneous action of two adjacent but opposing parallel forces. In a fall, the part of the tuber calcanei which strikes the ground is forced upward by the impact, while the articular portion is driven downward by the talus. Cartilage is driven violently against cartilage and the force of the compression produces irreversible subtalar damage. The extent of the compression may be indicated by the "tuber joint angle of Bohler" which generally has been accepted as a standard for evaluating fractures of the os calcis (Figure E). Tuber joint angle can be seen by projecting a line along the upper surface of the tuberosity and another through the subtalar joint. If a compression fracture has occurred and the subtalar joint is involved, the angle may be reduced or even become reversed. The normal angle varies between 10° and 40° and should be compared with the opposite side.

Types of Os Calcis Fractures

a. Fracture of the anterior end

of the bone involving the calcaneo-cuboid joint (Figure F).

b. Vertical fracture of the tuberosity.
c. Isolated fracture of the sustentaculum tali.
d. "Beak" fracture of the tuberosity.
e. Fracture involving but not displacing the posterior articular facet.
f. Fracture with depression of the lateral part of the articular surface.
g. Fracture with depression of the entire posterior articular surface.

Clinical Material

Four cases of various os calcis fractures are presented varying from comminuted fractures of the body with minimal subtalar joint involvement to severe comminuted fractures of both the anterior and posterior facets. Ages varied from the middle aged to the elderly, and all injuries were produced by a fall from a moderate height. Each was initially evaluated and treated by the same clinician.

Case #1 is a 51-year-old white female who sustained a moderately comminuted fracture of the body of the os calcis of her right foot with minimal involvement by the fracture of the posterior articular facet. She was treated in a short leg cast for two and a half months. After nine months, the patient has moderate limitation of subtalar motion and ambulation is slightly painful, but the patient is a housewife and states she can tolerate her discomfort. If she were a working person, a subtalar arthrodesis would be indicated.

Case #2 is a 48-year-old moderately obese white male who sustained a comminuted fracture of the right heel with moderately severe involvement of the subtalar joint. He was treated with a short leg cast (non-weight-bearing) for three weeks and then with a walking cast for eight weeks, during which time he had episodes of gouty arthritis of the feet and superficial thrombophlebitis of the right calf. At the end of six months of follow-up, most of the patient's complaints are secondary to medical problems other than the fracture. His calf and ankle remain swollen, but he has good subtalar motion with minimal residual pain.

Case #3 is a 75-year-old white female who sustained a moderately comminuted fracture of the tuber and body of the right os calcis without subtalar involvement by the fracture. The patient was treated in a short leg cast for one month and then a walking cast for an additional month. After the two months of treatment, the patient has no subtalar motion loss and is asymptomatic.

Case #4 is a 60-year-old white male laborer who sustained severely comminuted fractures of both os calcis involving both anterior and posterior articular facets. Both fractures were manipulated with the use of a Bohler "C" clamp and then placed in short leg casts. Ten months post-injury, ambulation and subtalar motion was very painful and limited bilaterally, but worse on the left. A subtalar arthrodesis was performed on the left and probably will be required on the right in the near future.

Conclusion

The reasons for disability associated with fractures of the os calcis are:

1. Avascular necrosis of a fragment.
2. Trauma to the fat pad of the heel producing residual discomfort.
3. Lateral spreading of the os calcis, impinging on the long peroneal tendons, producing a tenosynovitis.
4. Loss of power of the triceps surae to plantar flex the foot because of os calcis shortening or elevation of the posterior aspect of the heel.
5. Post-traumatic arthritis of the calcaneocuboid joint, producing pain on rotation of the forefoot.

But the most common cause of permanent associated disability is

6. Post-traumatic subtalar arthritis.

Subtalar arthritis most frequently occurs if the comminuted fracture involves the articular facets of the os calcis and may occur without direct fracture involvement. After studying the cases presented and cases of

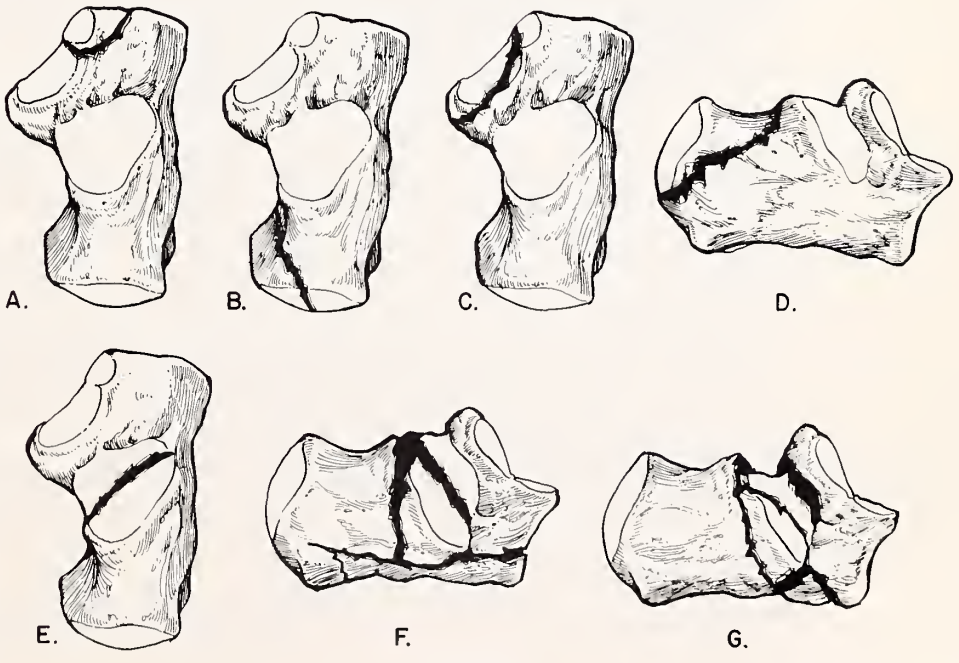


FIGURE F

others, we believe that if the comminuted fracture directly involves the majority of the subtalar joint, a subtalar arthrodesis should be part of the initial treatment of the fracture, thus markedly shortening the period of primary disability and morbidity. If the comminuted fracture does not involve the subtalar joint directly or the joint is minimally involved, a conservative approach is indicated, attempting to obtain as close an anatomic reduction as possible.

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New Indiana Law Pertaining to The Regulation and Licensing of Hospitals

SENATE ENROLLED ACT No. 311

AN ACT to amend IC 1971, 16-10-1 concerning the regulating and licensing of hospitals, and the authority of governing boards and medical staff.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 1971, 16-10-1 (formerly Acts 1945, c. 346) is amended by adding a new section to read as follows: Sec. 6.5. The governing board of the hospital shall be the supreme authority in the hospital, responsible for the management, operation, functioning and control of the hospital, and the appointment of the members of the medical staff and the assignment of privileges to members of the medical staff with the advice and recommendations of the medical staff consistent with their individual training, experience, and other qualifications. The medical staff of a hospital shall be an organized group which shall be responsible to the governing board for the clinical and scientific work of the hospital, advice regarding professional matters and policies to the governing board, and shall have the responsibility of reviewing the professional practices in the hospital for the purpose of reducing morbidity and mortality, and for the improvement of the care of patients in the hospital. This review shall include, but shall not be limited to, the quality and necessity of the care provided patients and the preventability of complications and deaths occurring in the hospital. The members of any medical staff committee organized for the purpose of conducting medical review, being retrospective and not a part of current patient care, shall have an absolute immunity from civil liability for communications made in committee meetings, and reports and recommendations made by the committee arising from deliberations by the committee to the governing board of the hospital or another duly authorized medical staff committee.

SECTION 2. (Emergency) Whereas an emergency exists for the immediate effect of this act, the act shall be in full force and effect on its passage.

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ELECTROCARDIOGRAM OF THE MONTH

Carotid Sinus Syndrome

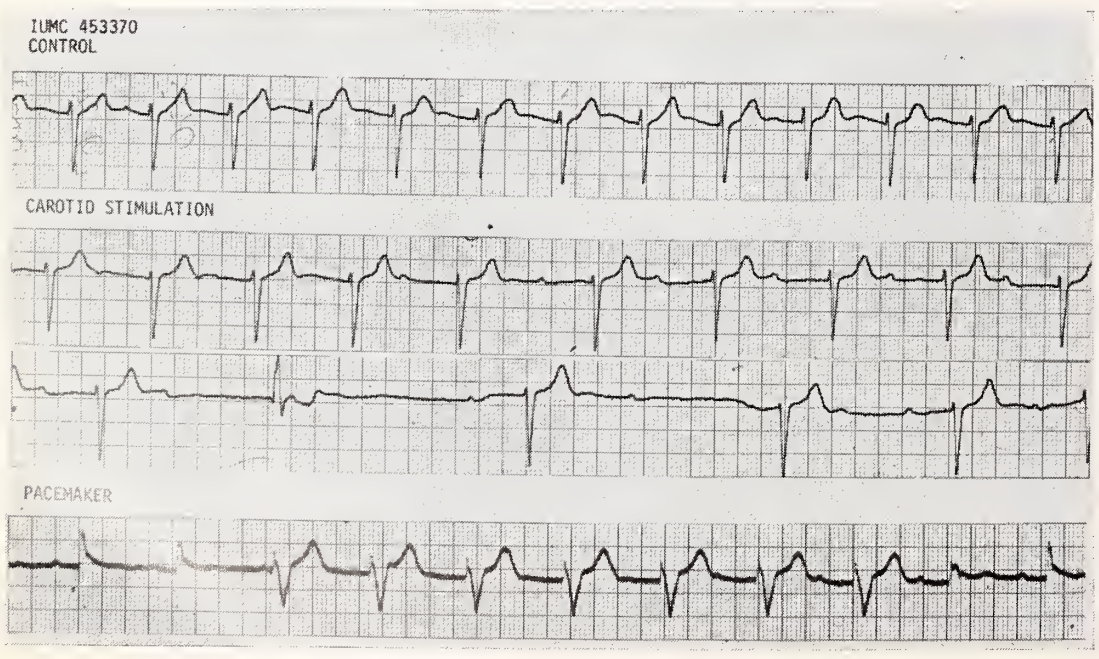
CHARLES FISCH, M.D.
*Indianapolis**

THE therapy of bradycardia due to carotid sinus syndrome has been, in general, unsatisfactory until the advent of demand pacemaking. The accompanying figure demonstrates the application of synchronized demand pacemaker in prevention of ventricular standstill due to carotid sinus sensitivity.

The control tracing (all lead V_1) shows a rate of about 80. The P wave is buried in the preceding T wave. The latter is clearly demonstrable with carotid stimulation. With slowing of the heart rate, the prolonged P-R interval (0.44 seconds) becomes evident. The degree of A-V block is enhanced with marked reduction of the ventricular rate.

With implantation of the demand pacemaker the bradycardia is prevented because the pacemaker assumes control whenever the ventricular rate drops to below 72, the preset pacemaker rate. ◄

* From the Krannert Institute of Cardiology, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis 46202.



CAROTID sinus syndrome controlled with demand pacemaker. For details, see text.



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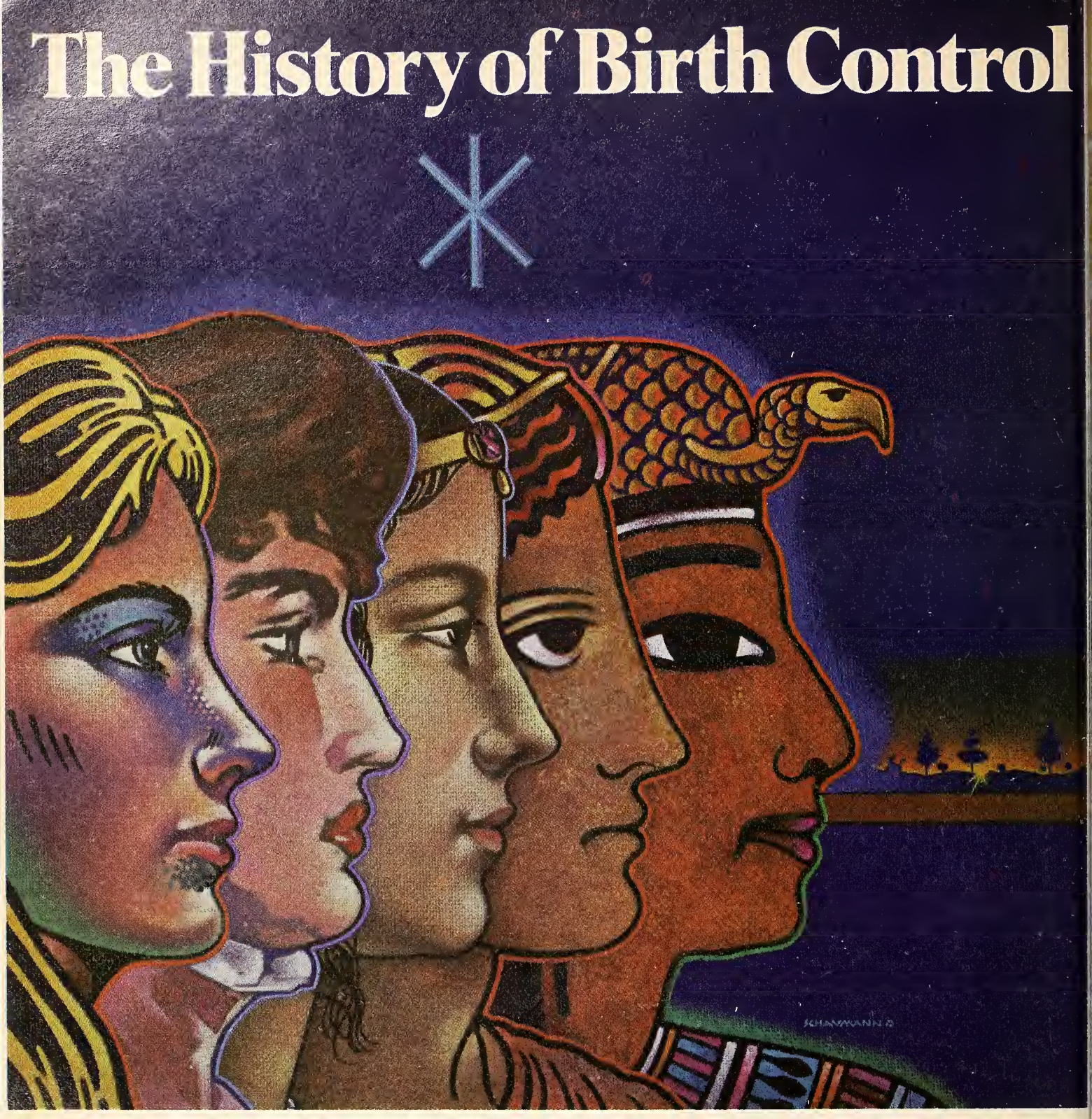
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Consommé	29	Tomato	69
Chicken with Rice	43	Cream of Asparagus	70
Chicken Gumbo	48	Cream of Chicken	76
Chicken Noodle	54	Cream of Mushroom	115
Cream of Potato	58	Green Pea	116
Chicken Vegetable	60	Cream of Shrimp (Frozen)	132
Vegetable Beef	66	Bean with Bacon	133

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The History of Birth Control



After a 4,000-year search, have women finally found freedom?

Abortion and infanticide have, throughout history, been the final and desperate resort of women who were unable to control their fertility, but for almost 4,000 years they have sought ways to prevent conception.

In ancient Egypt they used pessaries of crocodile dung or tried to clog the motile sperm with honey and a gumlike substance. The women of Islam used tampons of pomegranate pulp and rock salt. In Japan they burned little balls of "burning grass" on the *mons veneris* or, more practically, tried to cover the mouth of the uterus with disks of oiled bamboo tissue paper. In the 18th Century in France upper-class women rediscovered the vaginal sponge, a device mentioned in sources as old as the Talmud.

It may seem now that such advances as oral contraception and the IUD have freed women from this often fruitless search and consequent suffering, but there are millions of women in the United States and elsewhere who have less knowledge of, and less recourse to, contraceptio than Egyptian women of the Twelfth Dynasty. Nothing is more urgent to all of us than to bring them help. We cannot long support the ecologic pressures of an additional 70 million Earth inhabitants each year.

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Actions—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study of Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

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Where Do We Go?

AMERICA is having a dream. Yes, some will state in a vulgar way that it's "a wet dream." We have stark reality staring us in the face each and every day we conduct office hours, to say nothing of activity registered in the emergency rooms of numerous hospitals.

What is this reality? In just plain everyday language, without any medical embellishments—it's the gonorrhea, the gleet, the clap, G.C., a specific urethritis, a urethral discharge, a strain. Maybe some of you have other names to convey the idea of "what it's all about" to persons seeking our care and advice. (To me, the above-mentioned are sufficient.)

First of all, in my considered opinion, G.C. treatment is not an emergency. Late evening and early, early morning visits to round-the-clock emergency rooms should not be the occasion to institute treatment for the malady. By far, the average G.C. case has had "his or her dripping or discharge" several days before seeking medical attention. They have played their luck—finally decide they have lost—so the panic button is pushed. Medical attention must be sought immediately. NOT SO. Six or eight hours delay certainly will not be disastrous—but off to the emergency room they go, seeking the golden bullet. In most cases, he or she receives treatment. In many instances it is inadequate by any standard—sometimes just a bag or envelope of tablets and minimal instructions.

At the time of night the E.R. call is made, no bacteriologist or technician is on hand to make or examine or take a culture (rectal as well as urethral, vaginal or cervical) or smears. No routine blood sample is drawn for possible syphilitic infection. No follow-up arranged, no contact report, no report to the Board of Health. Treatment is given on a purely clinical basis. Payment is in most cases collected. The individual is returned to the streets on his own—in most cases, under-treated, uninformed. Free to do as he or she pleases. No contact investigation arranged.

The simple solution of the problem or procedure as described above is for all E.R.s to cease the treatment of all even suspected venereal disease cases or frank V.D. infections. Refer the person or persons to a physician who, you know, treats V.D. correctly and willingly or, if they are indigent, refer them to the local Board of Health clinic. There a proper, prompt, work-up will be done. Contacts will be discreetly sought and informed. A thorough follow-up will be outlined and carried out. The proper substitute drugs which are on hand will be used in case penicillin is not tolerated. Confidence established. Repeated blood tests arranged.

Send your cases of V.D. to a fellow physician in whom you have confidence for thorough treatment and handling of them or refer them to the Board of Health clinic. Many practitioners do not choose to have anything to do with V.D. cases. Choose one of the solutions mentioned above—"get them out of your hair." Permit the person to get correct, adequate treatment, follow-up, and, in a large number of cases, contacts investigated. Thus you can help stem the tide of V.D.

S. R. M.

P.S. Yes, G.C. is still the second most frequent communicable disease, trailing only the common cold.

P.P.S. If you are in doubt as to the correct treatment schedule of G.C. or syphilis, consult Fowinkle, E. W.: Gonorrhea; Fiumara, N. J.: Primary and Secondary Syphilis; and Wright, E. T.: Latent and Late Syphilis, in H. T. Conn (ed): *Current Therapy, 1971*, Philadelphia, W. B. Saunders Co., pp. 474-480.

Restraint Needed, Both Active and Passive

DESPITE the fact that seat belts have been demonstrated to minimize injury and prevent death in auto accidents the belts have one serious drawback—not enough people use them.

A few people bought seat belts when they were not required to and then sat on them. Most drivers who installed them voluntarily used the lap strap religiously and with good effect. However, when cars came with seat belts as a part of original equipment it was found that a great many people neglected to use them. The estimate now is that four out of five people don't buckle in.

The same may be said for shoulder harness, only more so. The estimate here is that 96 out of 100 don't use the shoulder harness. The combination of the two belts is the best safety factor extant. Wilbur Shaw, who was a good driver and not at all foolhardy, once said that he would not hesitate, if equipped with a good seat belt and shoulder harness, to drive a car at 65 miles per hour into a stationary object—and that he would not expect to be injured.

There must be many drivers and passengers in the U.S. who do not value such advice. All sorts of neatly worded admonitions have not instilled in them the habit of using active restraint systems—called active, no doubt, because some little brain action and even a smaller amount of manual action is involved in their appliance and use.

The federal agency in charge of such problems is the National Highway Traffic Safety Administration (NHTSA). The agency experts have suggested a contrivance in every car which would prevent the motor from starting until the seat belts are latched. They figure that the contrivance would have to be clever enough to prevent the user from latching the belt and then sitting on it.

The NHTSA people also have another idea—the passive restraint. This is devised to operate in protecting the auto passengers almost in spite of anything that can be done to render it ineffectual or inoperative. One such device is an air bag stowed in collapsed form under the dash. An impact sensor inflates the bag to considerable size so quickly that it interposes itself between the front-seat passengers and the portion of the car in front of them, in case of a front-end collision.

The air bag is also designed to collapse quickly and immediately after the inflation in order that it does not interfere with the driver in further controlling the car.

The air bag's chief advantage is that it will work without the driver having to do anything. However the universal installation of some type of passive restraint in the front seats of all passenger cars sold after Aug. 15, 1973, is planned and the government order has produced several varieties of objections—some economic, as in the case of the seat belt industry; some technical, as in the case of the auto makers who must devise and install and be responsible for the air bags; some medical, as in the case of those who think the sudden inflation will affect the ears; and some from those who think the system has not been tested enough as yet to warrant its universal requirement.

The government has not specified air bags, but even those who object to the bags on grounds that they are not highly enough developed as yet regard the air bag as the only possible example of passive restraint that could be used now under any circumstances.

The strictly medical objections relate to the ears. It may be possible that the loud noise which is created when the bag is suddenly inflated may, temporarily at least, diminish the hearing. It also may be possible that, if the air bag inflates when the car windows are closed, the air pressure within the car may be raised enough to damage ear drums.

All these considerations and many more will be debated during the next few years. Meanwhile, thousands of citizens are killed in autos and it is about time to have whatever devices will save lives, whether it involves more expense in building the car or produces ear trouble in the process. The air bags are, of course, limited in safety value to the front-end collision, but this is the wreck which produces death the most surely.

Whatever the time schedule is toward building more safety into autos, it should be hurried along as fast as possible. Maybe the medical motto for this should be that it is better to have a little ear trouble and be alive to know about it than to be completely deaf and dead in a front-end collision.

Guest Editorials

What Price Immortality?

IT isn't exactly true that we have immortality within our grasp. It is true, however, that every time death is driven back a step or two, we move in the direction of immortality. Indeed, death has been sent reeling and presently seems to stand vulnerable to the broadsword of medical research.

The ethical, moral, philosophical, and even economic consequences of this imminent development are awesome. For some time physicians have been faced with the twin ethical and moral questions of how long we should keep a vegetating humanoid alive. The Church has helped to a degree—we are not morally required to employ heroic measures to prolong life in hopeless circumstances. It remains for us to determine what is hopeless and what is heroic. But what yesterday was hopeless is today not quite so hopeless and what yesterday was heroic is today commonplace. Not too long ago a cardiac arrest successfully dealt with made headlines; today, it causes barely a ripple

in the ordinary routine of any busy general hospital. The medically unsophisticated might still be impressed and awed by intravenous fluid administration but in all likelihood it is an unusual patient who manages to depart the hospital without the experience of having been "fed through my veins."

It has been relatively easy to make the decision to stop the IV's and the oxygen on someone hopelessly brain-damaged or cachetic and in agony with terminal cancer. A more difficult decision is which patient will have the available heart or kidney transplant or perhaps the artificial heart or the new dialysis machine. We will shortly have the technical capability of outfitting some human with a new set of plastic blood vessels, an artificial heart, handy portable renal dialysis machine and portable pulmonary blood oxygenator. Living might be cumbersome with such impedimenta but it will also very likely have possibilities of being lengthy.

There can be no argument that this will be a very expensive existence. The question of who will pay the medical expenses is an intriguing one. Will it be an HMO? Medicare? A national health insurance plan? What person or what committee will finally decree that it is just too expensive to keep this person alive? And what shall be the cutoff point medically and/or fiscally?

The point to be made is that as immortality is approached, medical costs tend toward infinity. Health planners along with Congress are struggling with facts, figures, actuarial tables, computers, and, one might think, even crystal balls to establish projected costs for the various health plans. The truth of the matter is that if medicine is to be practiced to the fullest extent of its possibilities, there can be no cost limitations and no ceiling for total anticipated expenditures under any health plan.

If unlimited health care is to be given, health care cost will be unlimited. The type of health plan under which unlimited health care might be given would appear to be of very little consequence, for unlimited care would cost an unlimited amount of work, or time, or skill, or money under any plan.

These are not easy matters to contemplate or discuss. Our technical skills are creating social and moral problems as by-products of our medical successes. These problems must be dealt with by society as a whole rather than by the medical profession alone.

The conclusion appears simple enough: If medical costs are to be limited, medical care must be limited. Immortality comes dear. We probably cannot afford it. We will have to settle for just a bit of it.—**Stephen D. Ward, M.D., Reprinted from *West Virginia Medical Journal*, July 1971.**

Consumer Has a Lot to Lose from Consumerism

CONGRESS has recently passed laws governing consumer health and safety in everything from foods and fabrics to appliances and automobiles . . . requiring more standardized information concerning credit and package labeling . . . closely regulating drugs, cigarettes, toys, credit cards, household products, and a number of other consumer industries. And more of this legislation is in the cards.

Federal regulatory agencies and state and local governments are getting tougher, too.

This avalanche of activity springs from three principal motivations. The first is a sincere desire to assure the consumer a product free of defects, hidden dangers, and misrepresentation. With this aim, no legitimate businessman can quarrel.

The second motive is the "protection" of the consumer from his own failings. Proponents of this type of regulation always claim to be "for" the average man, but actually they hold him in complete contempt. They regard the typical consumer as a childlike innocent who must be watched over by a benevolent government serving *in loco parentis*.

The third motive is that of the people who are interested not so much in the welfare of consumers as in effecting radical changes in the business and social institutions of America. These people pretend to be pro-consumer when they are really only anti-business.

There is not much that can be done about the latter two groups. They will always be with us, in one form or another.

But the first group deserves special consideration. Consumers *do* have real problems and concerns about the workings of the marketplace, and the responsible businessman can ill-afford to disregard those problems.

On the contrary, the lesson of our experience during the past few years seems quite clear: If we dislike the wave of consumer legislation which has swept down upon us—if we distrust legislative solutions to consumer problems—then we really have no choice except to resolve those problems voluntarily, *before* government tells us how to do it.—**F. Ritter Shumway, President, Chamber of Commerce of the United States.**

Editorial Notes . . .

Loss of sleep is the mother of invention. A research and development technician found that he was losing sleep, ten hours at a time, three times per week, watching his wife's hemodialysis machine to be certain the blood level was not too high or too low. So—he invented a drip chamber monitor which sounds an audible alarm for either too high or too low. A slight side effect has been that the device was valuable for other things too—the inventor and his partner receive royalties from DEVCO.

The sensational reports about polychlorinated biphenyls (PCB) in foodstuffs packaged in boxes made from recycled cardboard give the impression that the problem has been discovered recently and that whatever industry is responsible has been careless. Not so. The paperboard packaging industry and the chemical industry have been monitoring and studying the situation for over a year. The PCB entered the cycle because it was once used in making office duplicating paper. When recycled this paper became cardboard. PCB has been discontinued for this use. Paperboard recyclers measure PCB content and limit its use in food containers.

The Veterans Administration has begun two pilot programs to train its practical nurses as professional nurses and its nursing assistants as practical or professional nurses. Students in this program will be paid as fulltime VA employees and will work at the hospitals as many hours as the study programs permit. If the pilot programs are successful, others will be started.

The United Mine Workers of America Welfare and Retirement Fund celebrated its 25th anniversary this year. It has dispensed more than $3 billion dollars in various benefits in that time. The fund is supported by a royalty payment—originally five cents per ton and now 40 cents. Administrative costs are around 3% of expenditures.

The World Health Organization is proposing that advanced countries eliminate routine smallpox vaccination because it is regarded in these areas as a greater risk than the disease itself.

Eighteen Veterans Administration hospitals are training Physician's Assistants in cooperation with 10 colleges and their medical centers. Training programs are based on Civil Service requirements. The trainees from the first course were hired by VA hospitals. Physician's Assistants perform diagnostic and therapeutic tasks under supervision of a medical doctor. They take medical histories, perform complete physical examinations, apply and remove casts, and suture minor lacerations.

The isotope californium-252, which is an intense emitter of neutrons, is now available for loan to foreign medical institutions for research concerning its usefulness in treating malignancy. For this purpose it is used in the form of needles. Due to its high cost ($10 per microgram) the needles will be used for other technical purposes after the radioactivity has decayed sufficiently to make medical use inadvisable.

The WFBM stations in Indianapolis have received a special award from the Community Service Council to recognize the public service which was inherent in the WFBM broadcast of the entire program of the Hoosier Teen Health Happening. WFBM preempted 12 hours of regular programming to telecast the two-day program. Afterwards, recordings of the entire conference were edited into three two-hour programs that were telecast later for even greater coverage. The recognition is especially concerned with businesses or industries for getting involved in community affairs.

The Federal Trade Commission and the Food and Drug Administration have cooperatively divided the authorities and responsibilties in connection with the monitoring and control of drugs, both over-the-counter and prescription variety, for many years. The two agencies have recently published a memorandum of understanding which alters to some degree the divisions and specifications of their joint task, and which replaces previous agreements of 1954 and 1968.

The memorandum states that FTC has responsibility for regulation of truth or falsity of advertising (not labeling) of foods, OTC drugs, devices and cosmetics. FDA has responsibility for preventing misbranding of foods, drugs, devices and cosmetics, and for regulation of prescription drug advertising. Liaison officers from each agency will plan coordinated programs and exchange information.

Veterans Administration hospitals are training nurses, nursing aides and technicians in increasing numbers each year. There are 16,284 students in professional nursing (RN) in 130 VA hospitals. The number of RN schools with the VA has increased to 304 or 23% of all professional nursing schools in the U.S. Four VA hospitals conduct refresher courses for RNs who wish to return to active nursing. The VA also trains practical nurses, nurse's aides, assistants, and technicians in significant numbers.



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8. Known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages or other securities: None.

9. For completion by nonprofit organizations authorized to mail at special rates (Section I32.I22, Postal Manual). The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes.
[X] Have not changed during preceding 12 months
[ ] Have changed during preceding I2 months
(If changed, publisher must submit explanation of change with this statement.)

I0. Extent and nature of circulation (A) Total No. copies printed 4,900 (net press run). (B) Paid circulation: I. Sales through dealers and carriers, street vendors and counter sales, 4,400. 2. Mail subscriptions, I00. (C) Total paid circulation, 4,500. (D) Free distribution (including samples) by mail, carrier or other means, 200. (E) Total distribution (sum of C and D), 4,700. (F) Office use, left-over, unaccounted, spoiled after printing, 200. (G) Total (sum of E & F—should equal net press run shown in A), 4,900. No. of copies single issue nearest to filing date are (A) Total No. copies printed (net press run), 4,900. (B) Paid circulation: 1. Sales through dealers and carriers, street vendors and counter sales, 4,400. 2. Mail subscriptions, I00. (C) Total paid circulation, 4,500. (D) Free distribution (including samples) by mail, carrier or other means, I50. (E) Total distribution (sum of C and D), 4,650. (F) Office use, leftover, unaccounted, spoiled after printing, 250. (G) Total (sum of E & F—should equal net press run shown in A), 4,900.

I certify that the statements made by me above are correct and complete.

James A. Waggener
Business Manager

Fires in hospitals, homes for the aged and other institutional buildings continue to increase both in number and in dollar loss, reports the National Fire Protection Association. There were 14,000 such fires last year, as compared with 12,300 in 1969, and costs were $17 million as compared with $13 million the previous year.

Reverse transcriptase is the enzyme capable of transferring information from the RNA of the leukemia tumor virus to DNA of animal cells. Upjohn scientists, working with researchers of Johns Hopkins, find that a group of antibiotics known as streptovaricins show some evidence of being able to inhibit reverse transcriptase. The streptovaricins have no effect on malignant cells but may be able to prevent the viral transformation from normal cells to malignant. If a practical use is found, the relative non-toxicity of the varicins will be of considerable advantage.

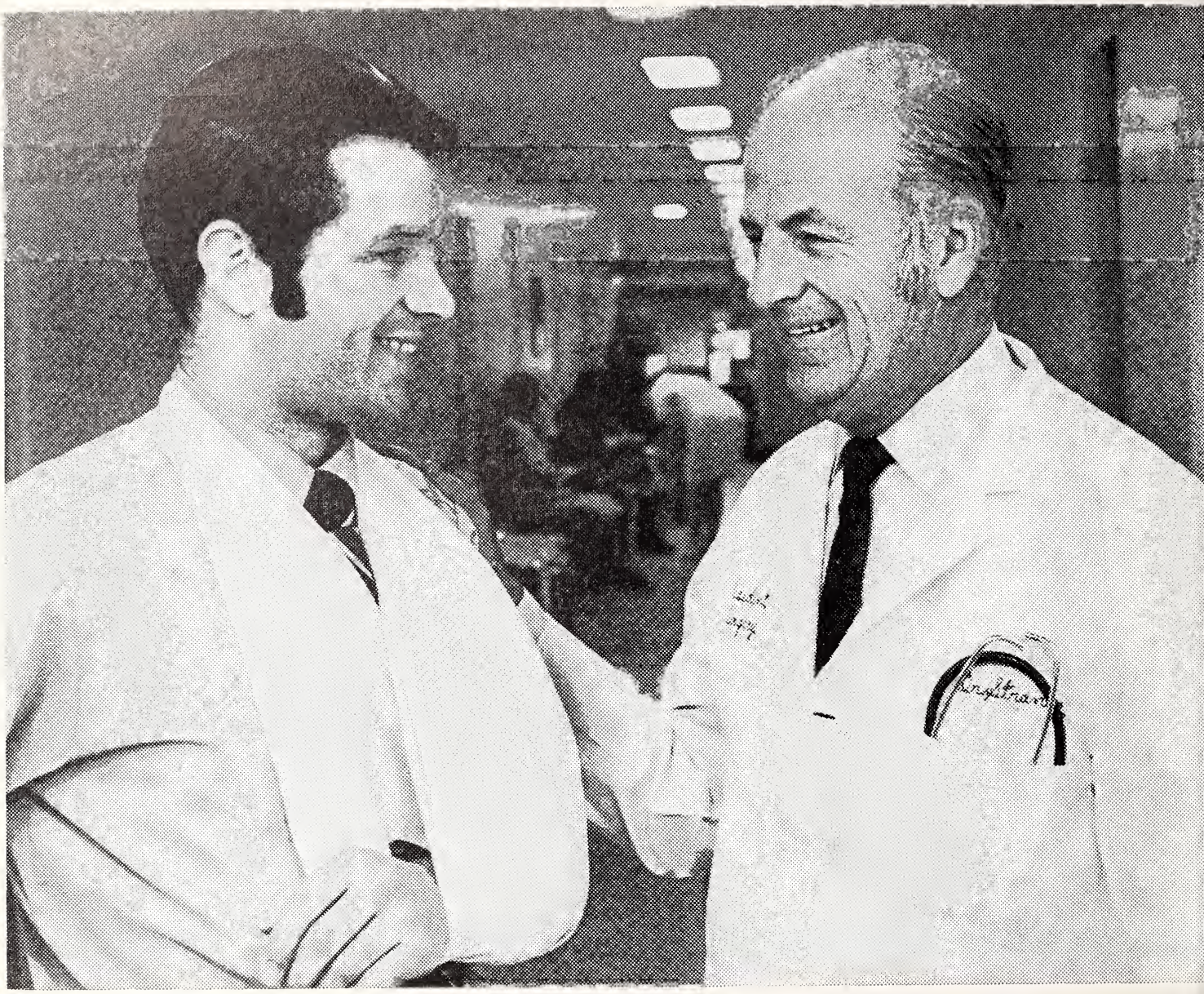
The United States mortality rate for those over 65 improved in the decade starting in 1956, and produced a more favorable rate than obtains in the highly industrialized countries of western Europe. Canada had a better rate than the U.S. The Scandinavian countries showed an increase in over-65 mortality but still have a lower rate than Americans.

Prices for retail prescription drugs rose only 1.6% in 1970 as contrasted with the all-items price index rise of 5.9%. The size of an average prescription has increased by 31.3% since 1960. The average charge for a prescription, on a dose-for-dose basis, shows a 5% decrease since 1960, reports John M. Firestone, Ph.D., professor of economics at City College of New York, who compiles the index and related data annually for the Pharmaceutical Manufacturers Association.

United States Technical Developments Sales Co. is announcing a new wall-mounted electronic thermometer which is intended to record body temperature by the use of an oral probe within 10 seconds. The device is said to retail for less than $100. The trouble with such a device is that, no matter how sophisticated the instrument is, it will not record body temperature by the oral route until the mouth has been closed for at least three minutes. Any reading, no mat'er how obtained, in a lesser time will give mouth temperature but not body temperature.

Airborne wound infection should be lessened in a newly equipped operating suite at Indiana University Hospital. During surgery a gentle breeze of sterile air flows over the patient and away from the operating table. The operating team is equipped with tight-fitting face masks, similar to scuba masks, which furnish air for the wearer's respiration and conducts exhaled breath to the outside. Rubber gloves and gowns are made more secure and air-tight. Colony counts in the new operating room have been as low as one colony per hour, as contrasted with 15 to 30 colonies in a conventional operating room.

Representative Paul G. Rogers (D., Fla.), chairman of the House Subcommittee on Public Health and Welfare, and general all-around savvy guy on things medical, is quoted as saying: "The benefits that will flow from health maintenance organizations are being oversold. They are no more the great solution that the Administration seems to claim than is the centralized system that Senator Kennedy advocates." ◄



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The Indiana Regional Medical Program—1969-1971

ROBERT B. STONEHILL, M.D.

*Indianapolis**

IN December 1971, the Indiana Regional Medical Program will have completed its first three years of operational activity. As the Program looks forward to the next triennium, it is a good time to take stock of what has been accomplished.

RMP had a broad charter, as stated by the rather exacting provisions of Public Law 89-239:

"PURPOSES

Sec. 900. The purposes of this title are—

(a) Through grants, to encourage and assist in the establishment of regional cooperative arrangements among medical schools, research institutions, and hospitals for research and training (including continuing education) and for related demonstrations of patient care in the fields of heart disease, cancer, stroke and related diseases:

(b) To afford to the medical profession and the medical institutions of the Nation, through such cooperative arrangements, the opportunity of making available to their patients the latest advances in the diagnosis and treatment of these diseases; and

(c) By these means, to improve generally the health manpower and facilities available to the Nation, and to accomplish these ends without interfering with the patterns, or methods of financing, of patient care or professional practice, or with the administration of hospitals, and in cooperation with practicing physicians, medical center officials, hospital administrators, and representatives from appropriate voluntary health agencies."

Under this concept an effort was made to gain the confidence and cooperation of all segments of the providers of health care in Indiana. One manner in which this was accomplished was through representation on the Regional Advisory Group, the policy making body which oversees the program, and on our numerous standing committees. We have, as a result, a Regional Advisory Group of 52 members with broad representation (see Table 1). In general, the cooperation of the health provider groups has been outstanding and tireless. A consortium of health care providers is now available who definitely maintain their own identity but who can and do cooperate to recognize health care needs in the state and plan to overcome demonstrated deficits.

Our funded activities and programs have largely been in the area of continuing education and demonstrations of the most advanced methods of quality medical care as well as demonstrations of innovations in medical care delivery. Each of the categorical diseases of heart disease, cancer, stroke and related conditions was covered.

A complete list of these program elements in 1971 and some of their accomplishments follows:

1. A Network of Coronary Care Units in Indiana

This proposal brought consultation and training in the creation and development of hospital CCUs to the practicing physician and other health professionals throughout Indiana. During the triennium, 420 physicians took the training course in coronary care and 125 ECG training slide sets were distributed to hospitals in the state. There were 62 coronary care units established during this period, not all with help from this project, however. The Coronary Care Com-

Indiana Regional Medical Program
REGIONAL ADVISORY GROUP REPRESENTATION

Association of Medical Clinics
Citizens Group
Communications
Comprehensive Health Planning 314b Agencies
Dental Association
Indiana Association of Licensed Nursing Homes
Indiana Association of Osteopathic Physicians and Surgeons
Indiana Hospital Association
Indiana State Board of Health
Indiana State Medical Association
Indiana University School of Medicine
Insurance
Labor
Medical Education
Nursing
Representatives of State Universities and Notre Dame
Voluntary Health Agencies

TABLE 1

* Coordinator, Indiana Regional Medical Program, 1300 W. Michigan St., Indianapolis 46202.

mittee had direct effect in 19 counties outside of Marion County. Also, telephone ECG transmission had been set up between the medical center and 17 outlying community hospitals.

2. Coronary Care Training for Nurses

Between January 1, 1970, and June 1, 1971, 87 professional nurses representing 12 of the 14 Governor's Planning Regions of Indiana completed the four-week course, Nursing in Coronary Care Units. Also, 15 senior baccalaureate nursing students were given the course as a feasibility study to the development of a senior elective course in the Indiana University School of Nursing.

3. Regional Stroke Program

This project surveyed Indiana hospitals to determine where stroke therapy services were inadequate or desired. Hospitals needing help in physical therapy, occupational therapy or speech therapy have dropped from 64 to 39. Each of the remaining 39 hospitals now has coverage from this project in at least one of the fields of therapy. This drop in the number of hospitals needing services was largely accomplished by mobilizing trained therapists who were inactive in their field of work. Also, 242 training and educational programs involving 1600 physicians, 2200 nurses and 416 other professionals were given in multiple sites throughout the state.

4. Multiphasic Health Screening

More than 10,000 persons from the disadvantaged inner city of Indianapolis have been screened to detect health abnormalities. More than 60% of those screened were found to have at least one abnormality and 40% of these people stated that they did not know of the abnormality prior to the screening. Those people with abnormalities were referred either to their private physician or to a clinic. In one sample of 467 patients referred to a neighborhood health center, 266 patients had treatment instituted as a result of the referral. The program utilized indigenous personnel who were specifically trained to perform the testing. Thirty technicians were trained to perform effectively.

5. Neighborhood Health Centers

Three neighborhood health centers were developed in the inner city of Indianapolis by the Metropolitan Health Council and were partially funded by the Indiana Regional Medical Program. These centers are linked for referral and backup purposes to Indianapolis community hospitals. They are designed to provide comprehensive primary care to the indigent. In 1969 there were 15,733 visits. In 1970 these visits increased to 27,600. Approximately 80% of the patients seen returned for follow-up care. Again indigenous community workers have been trained to work with the physicians and nurses. In addition, innovations in health care delivery, such as automated history taking and health hazards appraisal, are being tested.

6. Detection and Management of Chronic Pulmonary Disease

This program has been sponsored by the pulmonary disease physicians of the Indianapolis Veterans Administration Hospital. Physicians from widely located hospitals throughout the state have attended five-day courses in pulmonary disease given in Indianapolis. To date, 53 physicians have been intensively trained in the detection and management of chronic pulmonary disease. Nurses who worked with these physicians also attended the last course. Contact was maintained with all trainees after course completion through local one-day seminars at various hospitals. Largely as a result of these efforts the following facilities have been developed in outlying hospitals:

Pulmonary Functions Laboratories	8 New
Inhalation Therapy and Rehabilitation Centers	8 New
Respiratory Intensive Care Centers	4 New

7. Nursing and Allied Health Continuing Education

An Indiana Regional Medical Program Nursing Education Committee was formed with wide representation across the state. The Committee conducted a statewide survey of nursing education needs and subsequently developed a program. As a result, they conducted several courses to train nurses to teach in-service coronary care at their respective hospitals and 54 nurses completed the course. Seven in-service courses resulted. They conducted courses in "Basic Arrythmia Interpretation for Beginning Coronary Care Nurses" in regions 1, 6, 7, 8, 12 and 13 at the community hospitals and local nursing schools. They arranged for 16 nurses from seven regions in the state to attend the five-day course in chronic lung disease which was given in conjunction with the program mentioned in section 6 above. In addition, they have developed required action committees to work with their allied health counterparts. Finally, in September 1970 they, along with the Stroke Project and the Allied Health groups, held a three day conference "Perspectives on a Rehabilitation Theme: Interdisciplinary Function in Patient Care" for 50 participants.

In the allied health field, a group of conferences was held which stressed the interdisciplinary approach to therapy, community leadership development and specific interests of individual allied health disciplines.

8. Expansion of the Medical Library Extension Service

The TWX service between the Indiana University Medical School Library and public libraries in small

communities throughout the state was in existence prior to Indiana Regional Medical Program support. This system allowed practicing physicians outside of Marion County to contact their local library for reprint or literature review requests and have these requests transmitted to the Medical School Library. Usually within 24 hours copies of reprint requests were in the mail to the requesting physician. Indiana Regional Medical Program support allowed expansion of the system and the institution of other correlating services. For example, two seminars for untrained hospital library personnel from smaller hospitals and a workshop explaining the services available to hospitals from the medical school library were held in 1970. Eight hundred and seventy-two physicians from all the counties in the state have availed themselves of the TWX service. An average of 37 new physicians per month use the service which is a means of helping them conduct a program of continuing medical education at their own locale.



FIGURE 1
Coronary Care Project
COUNTIES in which consultation and/or other assistance was given in establishing Coronary Care Units.



FIGURE 2
STROKE PROGRAM
Counties with hospitals now participating in the project.
Counties with hospitals where RMP support has been phased out.
Counties with combination of above.

9. Technical Support to the IUSM Division of Post Graduate Medical Education

In 1968 the Division of Continuing Medical Education and the Indiana Regional Medical Program, with the help of the Indiana State Medical Association, conducted a survey among Indiana's practicing physicians of continuing medical education needs. A report of this survey was published in the January 1969 issue of *The Journal* of the Indiana State Medical Association. The survey showed that Indiana physicians felt that the visiting professorship program, formal courses, and medical television were the most effective

means of carrying on a continuing medical education program.

During the triennium, the Indiana Regional Medical Program helped financially support courses in continuing medical education which it has co-sponsored with the School of Medicine. These courses were only a part of the spectrum of postgraduate material presented by the School of Medicine and represented areas of recognized concern and interest of the Indiana Regional Medical Program. During this period, 30 courses in areas of heart disease, cancer, stroke, diabetes and respiratory disease were co-sponsored. This effort and the support of the Medical Library Extension Program ties in with the overall activities of the Division of Continuing Medical Education which utilizes a multifaceted and integrated program including:

a. postgraduate courses both at the School of Medicine and at community hospitals,

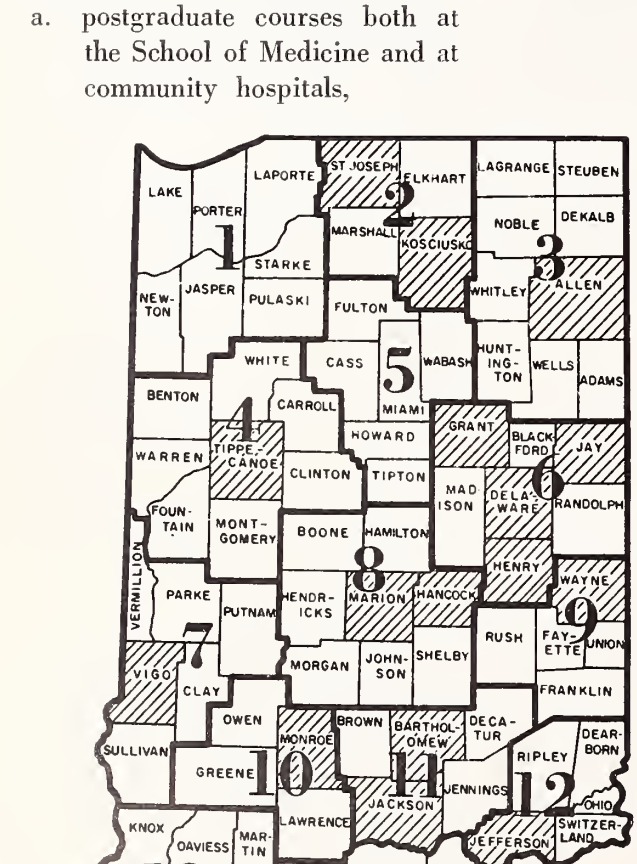


FIGURE 3
Chronic Pulmonary Disease Program
SEMINARS held in and/or trainees from these counties.

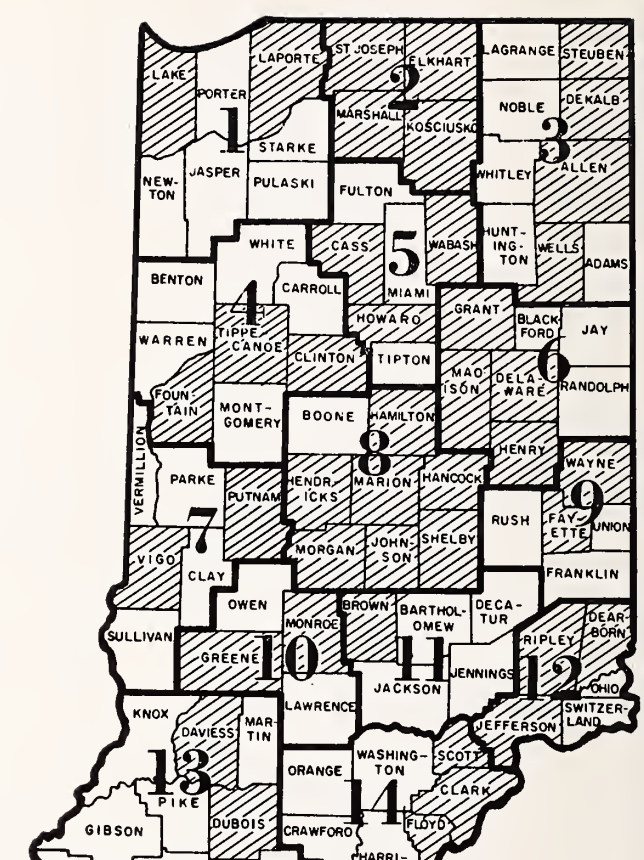


FIGURE 4
Nursing Continuing Education and Allied Health Sciences Activities
COURSES held in and/or trainees from these counties.

b. a visiting professorship program to community hospitals,
c. a medical education television network,
d. a comprehensive medical library service.

Thus, the methods of preferred continuing medical education expressed in the 1968 survey have been inaugurated and expanded.

The responsibility of the Indiana Regional Medical Program is to the whole state. As the School of Medicine and a concentration of sophisticated community hospitals with resource personnel are located in Marion County, most of the activities have emanated from there. However, only two projects, Multiphasic Screening and the Neighborhood Health Centers, are restricted to Marion County. The other programs have involved large segments of the entire

region. Activities have occurred in most of the counties and all of the 14 regions of the state (see Figures 1-5).

During the past three years and especially during the past year, IRMP has been trying to document the health care deficits which exist in the State. To assist in this identification, a series of surveys was conducted which has provided the Program with a wealth of data upon which to base a tailoring of its goals and objectives. In keeping with its roles as a co-ordinator of regional activities and as a catalyst, Indiana Regional Medical Program will make this data available to any group which would have use for it. Perhaps three examples of the type of material collected are now in order.

The consumer survey of the Charlestown area was conducted by a local action committee with support from the Indiana Heart Association, the Indiana Tuberculosis and Respiratory Disease Association, the Indiana State Board of Health and the Indiana Regional Medical Program. The local action group is now in the process of reviewing this survey in order to develop long-range health care plans. This group includes local businessmen, hospital administrators, and physicians. A methodology was developed which could be used by other communities within the State.

The second survey was conducted by the Indiana Regional Medical Program among the general practitioners in Indiana, in order to gain an understanding of their concerns in the areas of health care and to obtain a sampling of the types of patients seen in everday practice.

Finally, IRMP contracted with the management engineering staff of Indiana Hospital Services, Inc., to study the health deficits in Indiana. They studied three major subjects: prevalent diseases, health resources and financing of health care. Their report has a wealth of information which probably has never been brought together in one document before.

These data are being used by the Long-Range Goals and Objectives Committee of the Indiana Regional Medical Program during its review of the goals and objectives of the Program. This committee seeks to assure relevance of our aims to identified needs and to help establish a priority of goals in this era of restricted financing. This activity is especially germane now that the Regional Medical Programs Service in Washington has altered its method of financing the 56 Regional Medical Programs around the country. Instead of individual project approval and funding from Washington, each region will be evaluated to determine an overall funding level. Within that funding level the local Regional Advisory Groups will be given the authority to fund any or all of the activities they design into their Programs. At the moment, IRMP has six approved but unfunded projects in addition to the nine activities outlined earlier in this report.

It is the opinion of the Indiana Regional Medical Program that its limited funds should be used primarily as seed monies to help initiate activities which will be carried on from local resources. During the period of support the activities will have a time in which to prove their worth to the community. The final test of the value of a project will be its ability to gain funding from local sources. Thus, all new applications for projects must contain discussion of plans and possibilities for local funding at the end of IRMP support.

New proposals undergo an extensive and formal review by the various committees of the Indiana Regional Medical Program and eventually by

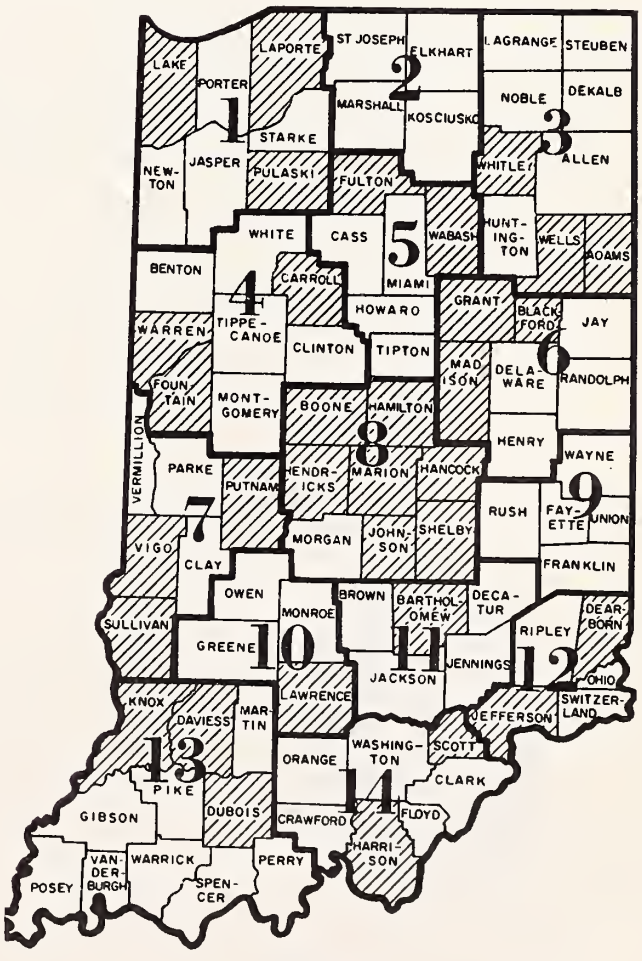


FIGURE 5

Nursing in Coronary Care Units Project
COURSE held in and/or trainees from these counties.

the Regional Advisory Group for approval and priority rating. Staff assistance is available in helping less sophisticated groups in developing proposals. In addition, early involvement of the local voluntary and public health agencies and planning councils and/or appropriate 314b Agencies of Comprehensive Health Planning is encouraged.

The endeavors of the Indiana Regional Medical Program during this triennium have been presented. They can be grouped into two major categories: continuing education for health professionals and demonstration projects of health care delivery. Projects in both categories have been designed to improve the delivery of health care to the citizens of Indiana. These activities have largely emanated from Indianapolis, but have involved nearly all areas of the State. Literally thousands of health professionals have participated in the program. We hope and believe that the end result has been improved patient care, as well as greater accessibility of health care. Indiana Regional Medical Program plans to continue its role as a catalyst, mobilizing local resources to attack the problems of health care delivery in conjunction with interested and dedicated local groups of health providers who respond to recognized local needs. ◄

Drug Quality Control: Problem with Digoxin[1]

In a recent monitoring program on digoxin tablets, the FDA's National Center for Drug Analysis reported that 47% of the batches investigated did not comply with the requirements of the USP monograph, chiefly because of failure in the content uniformity test. In one of the worst examples, NCDA found digoxin tablets containing twice the declared quantity of active ingredients. The same bottle contained tablets with 60-70% of the declared quantity. The manufacturers agreed to recall the violative lots. A follow-up program on digoxin tablets is underway, and the Bureau of Drugs is monitoring production to assure content uniformity of individual tablets.

On the basis of the digoxin findings, and other studies of diverse pharmaceutical products containing high potency drug substances in relatively low concentrations, FDA has concluded that direct tests for content uniformity are essential. Testing of bulk formulation material has proved unreliable as a measure of uniform content in individual dosage units. When such procedure is used, it is still possible for many of the tablets punched from the formulation mass to fall far outside permissible potency limits.

The significance of this finding to the prescribing physician is obvious: If a previously well-digitalized patient displays signs of under or over-digitalization, the problem may be with the drug rather than with the patient. Certainly, this possibility should be borne in mind when such signs appear.

The Food and Drug Administration is working to eliminate the problem of variable potency and its Bureau of Drugs has undertaken extensive investigations. In establishing the National Center for Drug Analysis, the Bureau has significantly expanded its capacity for gauging quality of drug control in general. As a result of the Center's marked success in developing automated methods of analysis and applying them to individual units of dosage forms, NCDA is now able to focus attention on problem situations involving deviations from content uniformity requirements.—*FDA Drug Bulletin,* Oct. 1971.

[1]Adapted from a paper delivered at the Mid-Year Meeting of the National Association of Pharmaceutical Manufacturers, February 14, 1971, at Washington, D.C., by Daniel Banes, Ph.D., Director, Office of Pharmaceutical Research and Testing, Bureau of Drugs, FDA.

Continuing Education for Physicians

POSTGRADUATE COURSES IN INDIANA

Adolescence: The Storm Before the Calm

March 1, 1972 — Methodist Hospital, Indianapolis

Combining lecture and clinical demonstration, this course covers certain unique problems presented by adolescent patients seen in general medical practice. Live and videotaped presentations will review special interviewing techniques and the annual psychological checkup. Staff members will discuss the management of parent-child conflicts, somatization reactions and common situational crises of this age group. One session will be a medical/legal discussion of the "age of consent" and the legal rights of both physician and adolescent. Also, one session will be devoted to discussion of professional parenting and residential/boarding school placement for teenagers.

Practical Endocrinology

March 15, 1972

Several important discoveries in the field of endocrinology and metabolism have led to a better understanding of mechanisms of endocrine syndromes and to the introduction of new diagnostic tests and therapeutic tools which have proved useful in clinical endocrinology. It is the purpose of this course to review some of these advances and place them in perspective with traditional diagnostic and therapeutic tools. Particular attention will be devoted to new areas of knowledge which can be incorporated in the day-by-day diagnosis and therapy of patients with endocrine or related disorders.

Anatomical and Clinical Otolaryngology 57th Annual Course

March 19-31, 1972

This offering is an intensive two-week course in anatomy of the head and neck with emphasis on surgical and developmental anatomy of this region. Thirty-six hours will be devoted to histopathology of otolaryngology. Lectures and demonstrations are designed to review basic principles and to present recent advances in the field. The course is open to recently certified or board-eligible physicians specializing in otolaryngology, as well as residents training in this specialty.

Presented by the Department of Otorhinolaryngology, the course is a cooperative effort on the behalf of faculty of the Indiana University School of Medicine: anatomists, anesthesiologists, internists and pathologists.

Psychiatry in General Practice

March 22, 1972 — St. Francis Hospital, Indianapolis

This six-hour course is designed to help the primary physician recognize and treat emotionally disturbed patients encountered in daily practice. Afternoon session, attention centers on the recognition and management of sex-related problems. Evening session, attention turns to the use of tranquilizers and antidepressants in medical practice.

Lecture presentations will be supplemented by ample forum discussion. Discussants will review basic, practical psychotherapeutic principles essential for the medical practitioner. ◄

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Warnings: USE IN PREGNANCY: Since safety of the use of this preparation in pregnancy, during lactation, or in the child-bearing age has not been established, use of the drug in such patients requires that the potential benefits of the drug be weighed against its possible hazard to the mother and child.

USE IN CHILDREN: The safe and effective use of this drug in children has not been established; therefore, the physician must weigh the benefits against the potential hazards.

Precautions: It has been reported that prolonged or excessive use of phenacetin may result in nephrotoxicity. Caution, therefore, should be exercised when Norgesic is administered to patients with renal disorders. It should also be used with caution in patients with tachycardia.

Adverse Reactions: Side effects of Norgesic are those seen with APC or those usually associated with mild anticholinergic agents. These may include tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased intraocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently an elderly patient may experience some degree of confusion. Mild central excitation and occasional hallucinations may be observed. These mild side effects can usually be eliminated by reduction in dosage. One case of aplastic anemia associated with the use of Norgesic has been reported. No causal relationship has been established.

Dosage and Administration: Adults—1 to 2 tablets 3 to 4 times daily.

Riker Laboratories, Inc.
NORTHRIDGE, CALIFORNIA 91324

A SUBSIDIARY OF 3M COMPANY

Norgesic...the versatile analgesic provides effective analgesia and relief of associated muscle spasm

Dr. Peter R. Petrich succeeded to the presidency of the Indiana State Medical Association during the annual convention in October.

Dr. Petrich has been active in the affairs of medical professional organizations since he started in practice in 1954. His devotion to his county medical society, to the district society and to the state medical association was culminated by service as president-elect during the term just ended. He is entering his term as our president after a year of planning and diligent work.

He is a native of North Bergen, N.J., and grew up in New York City. Prior to entering medical school he served in the Medical Department of the U.S. Army as a laboratory technician. He was stationed in the Panama Canal Department from October 1945 until November 1945.

He was graduated from Indiana State Teachers College in 1949 with a B.S. degree in science and then attended Indiana University School of Medicine.

Dr. Petrich received the M.D. degree from Indiana University in 1953 and then spent a year in internship at the Akron City Hospital. He has been engaged in general practice in Attica since then. He is on the medical staffs of the Williamsport Community Hospital and St. Elizabeth's and Home Hospitals in Lafayette.

He has served as City Health Officer of Attica for many years.

Dr. Petrich has been both secretary and president of the Fountain-Warren County Medical Society. He was delegate to the State Association from 1964 to 1967. In 1964 he was elected councilor from the 9th District Medical Society and was re-elected to that position in 1967. He participated in the change of the Council to the Board of Trustees and was chairman of the board in 1969.

He has also been chairman of the ISMA Commission on Medical Education and Licensure and was instrumental in initiating the current preceptor program.

Dr. Petrich is married. He and Mrs. Petrich have five children, three girls and two boys.



PETER R. PETRICH, M.D.
President
Indiana State Medical Association
1971-72

SAMA — MECO in Indiana

JANIE HENNEY

*Indianapolis**

INDIANA launched a new venture in medical education this past summer. Seven hospitals and clinics, 10 medical students and a multitude of hospital personnel participated in the SAMA-MECO Project of 1971.

The Student American Medical Association Project for Medical Education and Community Orientation (MECO) is a coordinated network of extramural programs organized on a statewide basis. This project rests on two assumptions: 1) that there are valid and worthwhile educational experiences available in health care institutions and communities throughout the United States which are beyond the present curricula and scope of medical schools; 2) that medical students can actively participate in the development of their own educational program as a part of an overall educational experience.

These two assumptions reflect two of the greatest needs in our present system of medical education. First, there is the need for physician education which more clearly reflects the geographic and specialty needs of society. For example, we lack physicians in rural areas, yet most of medical education occurs in specialty-oriented urban teaching centers. By exposing the medical student to a greater variety of health care settings, he will become more aware of society's needs and his own opportunities in medicine. And, for maximum effect, this exposure should come early in the medical education experience, before critical career decisions are finalized.

Another need facing the present system is the need to establish an effective continuum in medical education, starting with undergraduate education and extending to the postgraduate education of practicing physicians. By active involvement in designing his own educational program, the medical student develops a pattern of continuing self-education carrying beyond his formal training.

Although many aspects of the MECO project are not new, having been a part of many preceptorship and externship programs, the MECO project is the first formalization, on a national level, of the concept of extramural education as an important and integral part of undergraduate medical education.

The project originally was envisioned as a means for giving first-year medical students the opportunity to make their summer vacation an educational experience. In 1969, six freshman medical students spent their summer in a trial program at Illinois Masonic Medical Center in Chicago. This initial program proved that such experience expands the base of medical education by utilizing practicing physicians and community hospitals. Subsequently, the following long-range goals evolved:

1) Medical students should be afforded early association with health care facilities that they otherwise might not encounter.
2) Practicing physicians should become more aware of the problems and needs of students; conversely, medical students should develop an appreciation for the problems faced by practicing physicians.
3) Physicians and hospitals should have opportunity to become involved in programs designed to aid medical students and to advance medical education.

With the assistance of the Illinois State Medical Society and the Illinois Hospital Association, summer programs were established in 26 community hospitals in Illinois. These programs stressed exposure to clinical medicine and hospital operation and were under the direct supervision of physicians and staff; students rotated through a series of clinical and nonclinical departments: medicine, surgery, pediatrics, physical therapy, medical records, administration, pharmacy, etc. Students also had experience in the offices of private physicians of the community.

* SAMA-MECO Indiana State Project Director. During the past year Miss Henney has served as a tutor of emotionally disturbed children at Larue D. Carter Hospital, Indianapolis.



THE end of a long day finds medical student enrolled in SAMA-MECO program exhausted.

Early success in the project led to funding by the Sears Roebuck Foundation, which underwrote a three-year developmental grant to expand the project to a nationwide program. And this program became known as the SAMA project for Medical Education and Community Orientation (MECO). Summer of 1970, expansion efforts were concentrated in five midwestern states. The Illinois program was expanded to 54 hospitals with positions for 141 students, and an additional 26 hospitals with positions for 45 students became involved in Iowa, Wisconsin, Ohio and Michigan.

Following the 1970 programs, MECO was reorganized to facilitate further expansion. A coordinating committee, consisting of the student project directors from states having MECO programs, was convened to outline policy and guidelines for the project. Each student project director became responsible for developing the MECO project in his own state—with the cooperation of the state medical society, the state hospital association and the state academy of general practice. Such MECO programs have now been established in 20 states and this past summer more than 700 students participated in programs in 300 hospitals across the country. Endorsement of the projects has come from both the American Medical Association and the American Association of Medical Clinics, the latter having endorsed MECO for programs in group-practice clinics as well as hospitals.

The national SAMA office has undertaken a survey of students and doctors participating in the MECO project. This study will be available soon, but early reports have been enthusiastic. Of the 10 medical students and seven hospitals and clinics which participated in Indiana's first summer program, early returns indicate that the Hoosier program similarly has met with success. And, with continued support of the Indiana State Medical Association, the Indiana Hospital Association and the Indiana University School of Medicine, we look forward to expanding the MECO program in Indiana. ◄

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—September 1971

Disease	Sept. 1971	Aug. 1971	July 1971	Sept. 1970	Sept. 1969
Animal Bites	1236	1305	1445	845	913
Chickenpox	20	24	96	26	31
Conjunctivitis	146	138	282	127	74
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	42	20	46	37	5
Gonorrhea	910	647	834	754	656
Impetigo	235	128	176	243	176
Infectious Hepatitis	60	37	42	41	46
Infectious Mononucleosis	85	34	42	61	36
Influenza	584	279	820	543	588
Measles					
Rubeola	18	20	135	5	1
Rubella	72	51	103	57	26
Meningococcic Meningitis	1	1	1	0	1
Meningitis, Other	4	3	6	7	3
Mumps	37	57	150	63	56
Pertussis (Whooping Cough)	6	3	13	15	8
Pneumonia	209	158	286	198	139
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	639	539	580	512	333
Syphilis					
Primary & Secondary	28	20	44	21	39
All Other Syphilis	120	100	125	103	85
Tinea Capitis	4	1	0	5	3
Tuberculosis (Active)	74	47	60	65	62



ABSTRACTS, BOOK REVIEWS

AMERICAN MEDICINE IN CRISIS

Edward P. Luongo, M.D., Philosophical Library, Inc., New York, N.Y.; 1971; 195 pages; $9.95.

The title of this book is indeed deceptive, as the usual elements of the current debate about whether there is a crisis in American medicine—such as the distribution of health care services, the shortage of physicians, the rising hospital costs, etc.—are not really considered. Instead, Dr. Luongo gives us a scholarly treatise which traces the sociological and philosophical relationships of medicine against the historical perspective of time back to the world of the ancients.

The seven chapters of the book deal with the evolution of social, philosophic and technologic aspects of medicine, the semantics of medicine, the education and self-concept of the physician, the present language of the dispute in the delivery of medical care, through the alternative paths ahead for the healing art.

It is central to the thesis of this slender book that the physician by training and tradition is concerned with the welfare of the individual patient but is somewhat aloof from the welfare of society as a whole. The author describes the evolution of occupational medicine during the eighteenth and nineteenth century and decries the dehumanization of clinical medicine in Germany at the beginning of the twentieth century. He feels, in fact, that the subsequent evolution of medical education and the practice of medicine at the major medical centers throughout the world has been patterned along the early German model with an overemphasis on technology and scientific research. However, the statement by the author that "few modern medical educators show courage and conviction that the primary function is to train physicians not scientists; professional humanitarians not technicians" is certainly not supported by the fact that over 90% of all graduates of American medical schools over the past 50 years are engaged in primary patient care pursuits.

The author begins his final chapter with the admonition that "if we seek paths ahead for the healing art we must look beyond imminent partial conquests of infectious, degenerative and malignant disease; beyond problems economic and otherwise and delivery of quality medical care; and to imminent environmental, ecologic and ekistic problems."

He discusses the future of a wealthy society dominated by unlimited economic productivity yet having its members receive optimum benefits only in medical and physiological maintenance while unable to participate in the advances of its economic progress. Clearly, he sees unemployment and boredom as the major problems of an advancing technology.

The author states that, so far, we have seen the response of the healing art only to technological advance with priorities given to perfection of artificial organs, organ transplants and the application of computer technology. He feels that such priority decisions are open to serious question in light of the more compelling needs of a generally discontented, uncertain and unhappy society. To a large degree he states the healing art cannot escape responsibility for major societal problems of this sort. "What ultimate purpose is served in maintaining the physiological integrity of a large number of patients who must on recovery return to a society that has made many feel obsolete, unneeded as individuals?" he asks.

The final paragraph of the book focuses the central thesis of the author as follows: "The physician over the centuries on the whole has been concerned with and dedicated to the mending of bodies and minds. While there are modern practitioners who need to be reminded of holistic concepts in the practice of medicine, the great burden of the mending process in a torn, confused, and ravaged world obviously cannot be borne alone by the healing art; it must be shared, not only by those social sciences closely allied to medicine, but by all sources of responsible professional leadership in society. This places moral responsibilities, spiritual and otherwise, upon educators, the clergy, lawyers, politicians, and businessmen."

This book, then, provides neither a catalog of our present problems nor a list of ready solutions; instead Dr. Luongo describes the socio-economic forces which have been at work for centuries to mold the expectations of society relative to physicians in particular and medicine in general.

STEVEN C. BEERING, M.D.
Indianapolis

THE HEPATIC CIRCULATION AND PORTAL HYPERTENSION

Edited by Carroll M. Leevy and Richard C. Britton, N.Y. Academy of Sciences, New York City; 405 pages; $23.00.

In these days of concern about marijuana, hard drugs, amphetamines and other psychotropic agents, it is useful to revert to the fact known to the ancients that alcohol (ethyl hydroxide) is still the most dangerous of the widely abused mood-affecting substances. It is still a fact that some HALF—if not more—of our auto deaths have alcohol demonstrably a factor in their lethality.

In this symposium, we are brought back to earth and have presented to us the basic facts bearing on the gross and microscopic vascular anatomy of the liver effects of altered oxygen supply on hepatocytes, the microcirculatory basis for portal hypertension and the mechanisms of hepatic fibrogenesis that wind up in irreversible Laennec cirrhosis, ascites, etc.

It is eminently worth while recalling facts on which we have not thought since our student days. Practical therapeutics is within easy reach after we think of the "hepatic triad," "effective" blood volume, the "overflow" theory of ascites formation — just what can we do surgically? Even hepatic transplantation is considered.

All in all, a solid, down-to-earth effort well worth your time. I recommend it to your attention.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

DEVELOPMENTAL NEUROBIOLOGY

Symposium edited by Williamina A. Himwich, Charles C. Thomas, Springfield, Ill., 1970; 770 pages with numerous illustrations, tables and microphotographs; $44.50.

Two dozen distinguished experts each contributed a review of his particular portion of the field. At the end of the volume there is a staggering 100-odd pages listing alphabetically the couple thousand odd references available to the scholar in this expanding frontier of research.

As a scholarly endeavor this labor of love cannot be faulted. The sum total of the monograph also brings into vivid relief the fact that we still await the really informative answers. The ovum is

fertilized and starts the new individual. There is the well known gradient from the brain to the caudum. We hear the all-too-familiar tale of the germ layers.

The electron microscope gives us detail previously unknown. Because the neonate has a small brain that almost quadruples its weight within the first two years of the baby's life, we are again presented with the grim facts of what malnutrition does to stunt the mental development of the swarming children of the Third World.

We still await the answers as to just what makes clones of cells stop multiplying at the precise point in the individual's growth. Just how does the virus cease being latent and become the trigger for oncogenic transformation?

Monographs such as this one encourage the thought that we are much nearer to these basic answers. I envy my younger colleagues the fact that—long before the end of this century—the stunningly simple answers will be there for all to contemplate.

As usual, the binding, printing and typo-error-free work cannot be faulted. Every self respecting library should have this volume on its shelves.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

IMMUNOLOGICAL TOLERANCE TO MICROBIAL ANTIGENS

Annals of the N.Y. Academy of Sciences, edited by Herman Friedman, vol. 181, 1971; 315 pages.

A most impeccable pride of scientific lions with coruscating credentials gathered to discuss this topic which goes to the very crux of the problem of "Self" and "Unself": why does a cell or a whole organism accept a transplant in one instance and reject it in the next?

The very headings go the heart of the matter: "Immunological Paralysis, a Model System," "Cellular and Humoral Aspects," "Tolerance to LCM (Lymphocytic Choriomeningitic) Viruses," "Suppression by Oncogenic Viruses," "Cells and Signals in Immunological Nonresponsiveness."

The protein, flagellin, is an excellent antigen; it is an immunogenic agent that can be obtained in a pure state. How does it work? A good question! How does one produce immunological tolerance to the H-Antigens of Salmonella? Or tolerance and immunity to the LCM virus? Can anything be more pertinent to the question of acceptance or rejection of transplants?

It is quite heartening to know that we are learning the precise factors that must be matched in host and donor issues to assure acceptance. The idea now is to feed into a computer this precise pertinent data, transmit the information world wide, then get the exactly needed organ from somewhere in the world, fly it to the desired location and do the mechanical job. All the Christian Barnards will be pleased to hear of this projection when it becomes a fact.

As usual, this paperback comes well printed on excellent paper and without detectable errors. Well done, gentlemen!

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

Abstracts from Various Literature, Prepared by AMA

PERITONEAL DRAINAGE AND SYSTEMIC ANTIBIOTICS AFTER APPENDICECTOMY

C. J. Magerey et al. (Royal United Hosp., Bath, England)
Lancet 2:179-182 (July 24) 1971.

A prospective, randomized clinical trial has been carried out to determine the effects of peritoneal drainage or prophylactic systemic antibiotics on infection after emergency appendectomy in 329 patients. Drainage increased the number of days of postoperative fever significantly ($P < 0.01$) in patients with turbid peritoneal fluid and interfered with wound healing in all groups of patients. In three patients with drainage fecal fistulae developed. Antibiotics significantly ($P < 0.05$) reduced the number of days of postoperative fever in patients with perforated appendices without drainage. Antibiotics prevented the development of intraperitoneal complications but had no effect on wound healing.

COMPARATIVE ANALGESIA STUDY OF PROPOXYPHENE HYDROCHLORIDE, PROPOXYPHENE NAPSYLATE, AND PLACEBO

A. Sunshine et al. (Knickerbocker Hosp., New York 10027)
Toxicol. Appl. Pharmacol. 19:512-518 (July) 1971.

A total of 342 patients with postoperative or fracture pain were divided into seven groups and were treated with one of the following: 32, 65, or 130 mg of propoxyphene hydrochloride; 50, 100, or 200 mg of propoxyphene napsylate; or placebo. Each of the treatment groups experienced significantly more analgesia than did the placebo group, with the exception of those patients receiving propoxylene hydrochloride, 32 mg. Parallel dose-response curves were obtained for propoxyphene hydrochloride and propoxyphene napsylate. Propoxyphene napsylate is 1.25 to 1.49 times more effective than propoxyphene hydrochloride.

FATAL ARTERIOSCLEROTIC HEART DISEASE, WATER HARDNESS AT HOME, AND SOCIOECONOMIC CHARACTERISTICS

G. W. Comstock (Johns Hopkins Univ., Box 2067, Hagerstown, Md. 21740)
Am. J. Epidemiol. 94:1-10 (July) 1971.

Several reports have indicated an inverse correlation between the hardness of community water supplies and deaths from arteriosclerotic and degenerative heart disease. In Washington County, Maryland, drinking water sources vary markedly in hardness. A private census in 1963 made it possible to match cases and controls from the same defined population and to study a number of socioeconomic characteristics. During the next three years, there were 189 deaths attributed to arteriosclerotic and degenerative heart disease among white men age 45 to 64 years who could be identified in the census. For each case, two controls were randomly selected from the census lists and matched for race, sex and year of birth. Water samples were collected from the residences of patients and controls and examined for total hardness. No significant association of arteriosclerotic and degenerative heart disease deaths could be found with water hardness. Deaths from these causes were more common among persons of lower socioeconomic status, among cigarette smokers, and among persons who attended church infrequently.

CHANGES IN WATER HARDNESS AND LOCAL DEATH RATES

M. D. Crawford (London School of Hygiene and Tropical Medicine, London), M. J. Gardner and J. N. Morris.
Lancet 2:327-329 (Aug. 14) 1971.

Changes in the death rates of 11 county boroughs of England and Wales where the hardness of the water supply has been substan-

tially changed (for a variety of reasons) during the previous 30 years or so, were studied. In general, cardiovascular death rates showed a favorable effect in the towns where water had become harder and an unfavorable effect in the town where water had become softer, but this was not the case in non-cardiovascular rates.

GASTROINTESTINAL BLOOD LOSS DUE TO ACETYLSALICYLIC ACID: LONG-TERM STUDY

J. P. Kaltwasser and E. Werner (Dept. of Hematology, Univ. of Frankfurt, Frankfurt, West Germany)

Klin. Wschr. 49:927-930 (Aug. 15) 1971.

Blood loss after administration of acetylsalicylic acid (aspirin or Colfarit) was investigated in nine patients. Dosage was 1.5 gm/day given twice for periods of 14 days within 50 days. With each of the drugs blood loss was less than 5% of total blood volume within the test period. Microhemorrhages were observed in five patients. Since blood loss is minimal (less than 0.2% of blood volume per day), it may be neglected in clinical use.

ALLERGIC CONTACT DERMATITIS DUE TO INGREDIENTS OF VEHICLES

A. A. Fisher, F. Pascher and N. B. Kanof (45-14 48th St., Woodside, N.Y. 11377)

Arch. Derm. 104:286-290 (Sept.) 1971.

One hundred patients who were suspected of having allergic eczematous contact dermatitis due to topical medications were patch tested with a "vehicle tray" composed of 15 substances commonly found in bases and vehicles of current topical preparations. Positive tests were obtained in 30 of 100 patients. There were 18 reactions to ethylenediamine, 6 to lanolin, 3 to parabens, 2 each to phenylmercuric acetate, thimerosal, dichlorophene, propylene glycol monostearate and triethanolamine, and 1 to sorbic acid—a total of 40 positive reactions. No reactions were elicted to hexachlorophene, sodium lauryl sulfate, polysorbate, Tween 20, cetyl alcohol, or chlorobutanol. The study shows that vehicles play a significant role in producing cutaneous sensitization and allergic contact dermatitis.

CHROMOSOME ABERRATION IN CHILD OF KIDNEY TRANSPLANT RECIPIENT

D. E. Leb (Presbyterian-Univ. Hosp., Pittsburgh 15213), B. Weisskopf and B. S. Kanovitz.

Arch. Intern. Med. 128:441-444 (Sept.) 1971.

Chromosomal damage was found in peripheral blood lymphocyte cultures obtained at birth from the child of a kidney transplant recipient on a regimen of azathioprine. Subsequently the changes disappeared. Chromosome abnormalities were also found in the transplant recipient. The findings are consistent with the available reports of the effects of azathioprine and bring to light the problem of persistent damage to the infant's chromosomes and the relationship of chromosome damage to cancer.

CRETINISM ASSOCIATED WITH MATERNAL SODIUM IODIDE I 131 THERAPY DURING PREGNANCY

H. G. Green et al. (Univ. of Washington, Seattle 98105)

Am. J. Dis. Child. 122:247-249 (Sept.) 1971.

A 4-year-old girl with severe hypothyroidism, whose mother rereceived four courses of iodine 131 therapy during pregnancy. is reported. A review of previously reported cases and a brief discussion of the possible mechanisms of fetal thyroid damage by radioactive iodine are also presented. The need for close follow up evaluation of any infant whose mother received iodine 131 during pregnancy is emphasized.

OBSERVATIONS ON HEROIN AND METHADONE WITHDRAWAL IN NEWBORN

A. M. Reddy, R. G. Harper and G. Stern (State Univ.-Kings County Hosp. Center, Brooklyn, N.Y. 11203)

Pediatrics 48:353-358 (Sept.) 1971.

In 85% of 40 infants born to heroin-addicted mothers, withdrawal symptoms consisting of central nervous system, gastrointestinal and respiratory disturbances developed, sometimes within hours of birth. Respiratory depression at time of delivery was not a prominent feature of these infants. Although the morbidity was high, the mortality of treated infants was quite low. Withdrawal symptoms were also observed in infants born to methadone-maintained mothers. The course of these infants was similar to heroin withdrawal. Pediatricians should be aware that infants born to methadone-maintained mothers may be severely compromised in the neonatal period.

EPIDERMOID CARCINOMA OF LIP AFTER RENAL TRANSPLANTATION

H. M. Berger et al. (School of Medicine of Porto Alegre, Federal Univ. of Rio Grande do Sul, Porto Alegre, Brazil)

Arch. Intern. Med. 128:609-612 (Oct.) 1971.

Two young adults received successful related living donor renal transplants, and at two and three years postoperatively, each developed an epidermoid carcinoma of the lip. The statistical improbability of carcinoma of the lip at this age suggests that the neoplasms are related to transplantation, or immunosuppressive therapy, or both. These observations support the reports of an increased incidence of neoplasia in patients with transplants.

RIGHT VENTRICLE PERFORATION BY POLYETHYLENE CATHETER

T. F. Appel and P. J. Harbrecht (VA Hosp., Louisville, Ky. 40202)

Amer. Surg. 37:91-94 (Feb.) 1971.

Perforation of the right ventricle in one patient resulted from use of a long intact polyethylene catheter inserted through an arm vein to obtain central venous pressure readings and facilitate infusion of fluids.

REVIEW OF TOXICITY OF HEXACHLOROPHENE

R. D. Kimbrough (Food and Drug Administration, Chamblee, Ga. 30341)

Arch. Environ. Health 25:119-122 (Aug.) 1971.

Hexachlorophene is used extensively as a bactericide and fungicide. Ingestion of repeated high doses of hexachlorophene caused paralysis in rats and a peculiar edema of the white matter of the central nervous system. This lesion has previously been produced with triethytin. Because of these findings the toxicity of hexachlorophene in humans was reviewed. A single dose of 250 mg/kg hexachlorophene is fatal in children and 300 mg/kg is fatal in adults. Repeated oral doses of 20 mg/kg cause toxic symptoms in adults. Hexachlorophene can be absorbed through the intact denuded skin. Symptoms of toxicity after oral ingestion include anorexia, nausea, vomiting and diarrhea. Central nervous system symptoms which can occur after oral or dermal absorption include convulsions, nystagmus and muscle twitching.

OCCURRENCE OF MALIGNANCY IN IMMUNODEFICIENCY DISEASES

R. A. Gatti, and R. A. Good (Univ. of Minnesota, Minneapolis 55401)

Cancer 27:89-98 (July) 1971.

The incidence of malignancy in patients with immunologic deficiencies is roughly 10,000 times that of the general age-matched population. A review of the literature indicates that each type of immunodeficiency has a distinctive constellation of malignancy associated with it. Recent studies demonstrated both immunologically aggressive lymphocytes and the presence of blocking antibodies in the blood of neuroblastoma patients, so that a major role for immunity in oncogenesis seems almost certain. The role of blocking antibodies in the formation of lymphoid malignancies, such as occur so frequently in patients with immunologic deficiences who often do not produce well antibodies of any type, remains unclear.

SPONTANEOUS REESTABLISHMENT OF RENAL FUNCTION AFTER COMPLETE OCCLUSION OF RENAL ARTERY

S. J. Dobrzinsky et al. (S. A. Edwards, Peter Bent Brigham Hosp., Boston 02115)

Arch. Intern. Med. 128:266-268 (Aug.) 1971.

A 47-year-old housewife was known to have normal renal function in 1963. She later developed hypertension and in 1967 had a nonfunctioning left kidney and total occlusion of the left renal artery. She refused nephrectomy and was managed medically with improvement of her hypertension. By 1968, although the renal artery remained totally occluded, revascularization through collateral channels was so effective that an intravenous pyelogram gave no indication of occlusion. Renal vein renin activity was equal and normal on both sides. Parallel with the functional improvement, her hypertension became mild and easy to control.

STUDY OF SOME FAILURES IN METHADONE TREATMENT

M. E. Perkins (10 Nathan D. Perlman Pl., New York 10003) and H. I. Bloch

Amer. J. Psychiat. 128:47-51 (July) 1971.

The authors conducted a follow-up survey of 66 patients who had dropped out of a methadone maintenance program. Six had died since discharge. Of the 53 who were located and interviewed, 34 had been hospitalized for physical or mental conditions or for detoxification. Though 13 had not been arrested since discharge, the others accounted for more than 110 arrests, 78 incarcerations and 63 convictions. Except among the 15 who were then institutionalized, with abstinence enforced, the use of heroin continued to be a dominant activity: only two were in methadone programs and only two had been abstinent for a significant length of time. A greater effort should be made to retain addicts in methadone programs in order to improve their chances of rehabilitation. ◄

TO FILL YOUR PRESCRIPTION, SOME "DRUG" STORES SEND YOU:

down the stairs

past the snow shovels, past the luggage

around the clothing, around the furniture

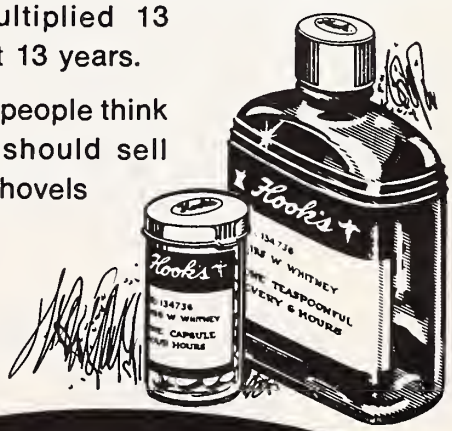
by the groceries and past the men's room

WE THINK THAT'S GOING TOO FAR!

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We regard prescription filling as a science, not just a sideline. Using this approach, Hook's prescription business has multiplied 13 times over the last 13 years.

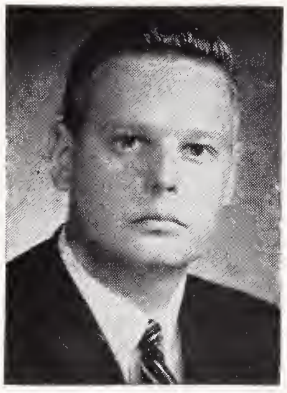
Apparently a lot of people think real drug stores should sell drugs, not snow shovels



Hook's

DEPENDABLE DRUG STORES

TAX TIPS



by LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

THE new Indiana Trust Code has many provisions in it that are significant to estate planners and to their clients. Therefore, you may want to have your lawyer examine your trusts and wills in order to see whether you want to make any changes due to the new law. Four provisions of interest are:

1. Trustees are granted broad administrative powers which apply in the absence of contrary provisions in the trust indenture.
2. There are many new rules concerning the treatment of receipts and disbursements by a trustee—e.g., a trustee may, in general, charge income with a reasonable allowance for depreciation under generally accepted accounting principles. If a charge is made, then the income beneficiary will, obviously, receive less income and the trustee will be taxed on such income (and, the trustee, instead of the beneficiary, will benefit from the depreciation deduction) for income tax purposes.
3. A trustee's normal compensation is chargeable to income (rather than to corpus), and thus, an income beneficiary will have to forego some of his income.
4. Oral trusts for personal property are abolished.

Most of you are aware of the new federal income tax filing requirements concerning non-profit organizations. However, do you know that such organizations must also file an application for a tax-exemption from the Indiana income taxes? The form that non-profit organizations should file is Form IT-35A.

Rev. Rul. 71-412 was recently issued by the I.R.S. This ruling provides that—if an employer establishes a plan to reimburse employees in an amount up to $36 per day for ordinary and necessary general business travel expenses and/or a plan to reimburse employees for transportation expenses in an amount up to 15¢ per business mile—then the substantive and accounting proof requirements of I.R.C. section 162 and section 274 (and of the applicable Regulations) will be considered to be met, so long as the former time, place, and business purpose requirements are also met. Unfortunately, the new ruling does not apply to persons who own 10% or more of the business. However, higher allowances for other employees may be obtained by writing to the Commissioner. Presumably, many employers may want to revise their reimbursement plans, because of this new ruling.

Last month the Tax Court held that I.R.C. section 79, which excludes premiums paid by employers on up to $50,000 of group-term life insurance, applies only to insurance purchased for employees (just as the Code states), and, since members of the board of directors are not considered to be employees (as a result of the director's directorships), section 79 does not apply to directors unless they are also employees—e.g., officers in the employer-corporation. See *Maurice A. Enright*, 56 T.C. No. 98 (1971).

The I.R.S. appears to be increasing its "net worth" audits in all parts of Indiana. And, if this is true, then this is just one more reason lawyers should be brought into all types of tax investigations at the earliest point of the investigations. ◀

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prescribing information appears on next page

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In addition to pain, this patient has experienced anxiety, fear, embarrassment, anger, and frustration. It's very likely that these psychic factors actually accentuated his perception of pain. Surely the last thing he needs is an analgesic containing caffeine. A much more logical choice is Phenaphen with Codeine. It provides a quarter grain of phenobarbital to take the nervous "edge" off, so the rest of the formula can control the pain more effectively. It's no accident that the Phenaphen formulations contain a sedative rather than a stimulant. Don't you agree, Doctor, that psychic overlay is an important factor in most of the accident cases you see?

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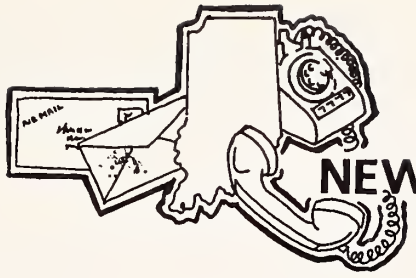
Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine phosphate, ¼ gr. (No. 2), ½ gr. (No. 3) or 1 gr. (No. 4) (warning: may be habit forming).

Indications: Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. *Contraindications:* Hypersensitivity to any of the components. *Precautions:* As with all phenacetin-containing products, excessive or prolonged use should be avoided. *Side effects:* Side effects are uncommon, although nausea, constipation and drowsiness may occur. *Dosage:* Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

A. H. Robins Company, Richmond, Va. A·H·ROBINS

Dimetapp Extentabs®

INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.
CONTRAINDICATIONS: Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.
WARNINGS: *Use in children:* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.
PRECAUTIONS: Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.
ADVERSE REACTIONS: Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis and thrombocytopenia; drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS-depressant and (less often) stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress.
HOW SUPPLIED: Light blue Extentabs in bottles of 100 and 500.



NEWS NOTES

College of Surgeons Inducts Twenty Hoosier Physicians

The American College of Surgeons announces the induction as Fellows of the College of the following Indiana surgeons:

Robert W. McCurdy, Anderson; **Claude E. Davis, Angola; James H. Booze, Charles B. Emery, Jr., and Michael A. Surian, Bloomington; Henry G. Giragos, East Chicago; Thomas P. Krueger, Evansville; Jack L. Gumbert** and Alexander R. Strilbyckyj, **Fort Wayne; Eugene P. Gregoline, Gary.**

Also, **Sohrab Amini, Huntingburg; Merrill A. Ritter, Indianapolis; Sterling P. Tignor, Kokomo; William G. Mentzer and David J. Trout, Lafayette; William A. Shuck, Jr., Marion; Charles L. Goodell, Muncie; Vernon Bundy, New Albany; Kenneth S. Woodman, Richmond; and Roland B. Mernitz, Jr., Wabash.**

Family Practice Exam Set

The American Board of Family Physicians announces that it will give its next examination for certification in various centers throughout the United States. The examination will be over a two-day period on April 29-30, 1972. Information regarding the examination can be obtained by writing: Nicholas J. Pisacano, M.D., Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center Annex #2, Room 229, Lexington, Ky. 40506.

Deadline for receiving completed applications in the Board office is February 1, 1972.

Dr. Pearson Elected President

Dr. John S. Pearson, Indianapolis, vice president of the American United Life Insurance Company, has been elected president of the Association of Life Insurance Medical Directors of America. He succeeds Dr. Harry A. Cochran, Jr., Fort Wayne, who is the senior medical director of Lincoln National Life.

Addresses Institute of Medicine

Dr. Steven C. Beering, Indianapolis, will be the luncheon speaker at the 1971 Workshop of the Institute of Medicine of Chicago on Friday, November 19, at the Ambassador West Hotel. Dr. Beering's subject will be "Community Hospitals and Medical Schools—the Indiana Experience."

Kidney Disease Committee Chosen

According to **Dr. A. C. Offutt,** State Health Commissioner, the Indiana State Board of Health has initiated a plan to implement and comply with the requirements of Indiana's new law pertaining to kidney disease.

An advisory committee to the board will make recommendations regarding the type of patient which can be helped, the standards of eligibility and the agreements which will be needed for state aid.

Physicians serving on the committee include: **Stuart A. Kleit, M.D.,** of the Indiana University Medical Center, chairman;

William R. Clark, Jr., M.D., Fort Wayne, secretary; **George W. Applegate, M.D., Indianapolis; Frank H. Green, Jr., M.D., Rushville; Loren H. Martin, M.D., Indianapolis; Vincent J. Santare, M.D., Hammond;** and Dana L. Shires, M.D., Indianapolis.

Sterling Drug Promotes Dr. Wescoe

Dr. W. Clarke Wescoe, who was recently chosen vice president for medical affairs for Sterling Drug, has been appointed executive vice president for research and medical affairs. Dr. Wescoe has been serving as president of Winthrop Laboratories, Sterling's major pharmaceutical division.

Named Cardiology Fellow

Dr. Robert D. Robinson, Jr., Bloomington, has been granted Fellowship in the American College of Cardiology. Dr. John F. Phillips, Indianapolis, the ACC Governor for Indiana, announced that Dr. Robinson was one of 105 physicians from the United States and Canada recently admitted to the College's highest membership classification.

Offer Oxygen Systems Booklet

The National Fire Protection Association announces a recently revised publication on "Standard for Bulk Oxygen Systems at Consumer Sites." It is for sale at $1.00 per copy. Write the Association at 60 Batterymarch St., Boston, Mass. 02110.

Speaks to Prospective Students

Dr. Henry T. Russell, director of the School of Medical Technology and the director of clinical and pathology laboratories, St. Elizabeth Hospital, Lafayette, spoke to a group of 45 prospective medical technology students recently. The students were from Purdue and Ball State Universities and St. Joseph College.

Addresses Cancer Delegates

Dr. Frank Lloyd, Indianapolis, chairman of the Research Advisory Committee of the United Cancer Council, was a featured speaker at the annual meeting of the UCC at Notre Dame last month.

Attends Surgeons Clinical Congress

Dr. Ian S. Templeton, Seymour, attended the 57th annual Clinical Congress of the American College of Surgeons in Atlantic City, N.J. recently.

Receives Cancer Research Prize

Dr. George Weber, Indianapolis, professor of pharmacology, Indiana University School of Medicine, has been awarded the Alecce Prize for Cancer Research by the Italian Pharmacotherapeutic Institute of Rome.

New PMA Booklet Clarifies Drug Prescribing Issue

There needn't be a big mystery when a doctor prescribes one of today's modern medicines. That's the basic message in a new 16-page booklet for consumers released this week by the Pharmaceutical Manufacturers Association.

Entitled "When It Comes To Rx Medicines, There Are a Lot of Questions You Should Ask," the colorful pocket-size booklet examines the methodology of prescribing and some of the long-standing controversies related to it.

The booklet is primarily a condensation of another PMA document published earlier this year for health professionals and for those concerned with America's health care delivery system. While the earlier book, *Brands, Generics, Prices and Quality—The Prescribing Debate After a Decade* (May 1971), was prepared to provide information that is essential in forming public policy, the purpose of the shorter pamphlet is to educate the patient, as a consumer.

"Many of the issues have been noisily garbled," said PMA President C. Joseph Stetler. "So with this book, we have attempted to place some of the questions in perspective for the average consumer."

"About 90% of the prescribing is done by trademarked name," the booklet notes. "Given the variety and subtlety of disease, variations in patient response, the range of products available and the natural tendencies of doctors to rely on companies with which they are familiar, this is hardly surprising."

"Hence, it is the consumer who should insist upon high standards of quality and upon strong private support for creative research against disease. Such encouragement can do much to assure success in improving today's medicines and in seeking tomorrow's," the booklet concludes.

Copies of the booklet are available upon request from the Public Relations Division, Pharmaceutical Manufacturers Association, 1155 Fifteenth St., N.W., Washington, D.C. 20005.

The PMA represents firms that make about 95% of the nation's prescription medicines.

Named to Cancer Board

Two Richmond physicians were elected to serve on the state board of the American Cancer Society at the division's annual meeting recently.

Drs. John Spellmeyer and John Wambo were elected to serve until 1973.

Additional ABFP Charter Diplomates Announced

Two Vigo County and one Whitley County physician have been named charter diplomates of the American Board of Family Practice. They are: **Drs. Robert L. Meissel and Renate G. Justin, Terre Haute, and Dr. Joe Bill Mishler, Pierceton.**

Dr. Hedde Re-Elected

Dr. Eugene L. Hedde, Logansport, was re-elected vice chairman of the Region 4 Red Cross Blood Program recently. In addition to serving as a district officer, Dr. Hedde is a member of the regional executive committee through 1972.

"Drug Misuse" Booklet Offered

"Drug Misuse: A Psychiatric View of a Modern Dilemma" is a 48-page booklet prepared by the Committee on Mental Health Services of the Group for the Advancement of Psychiatry. It contains a series of recommendations for strengthened efforts to cope with the causes and effects of drug misuse. It is for sale at $1.00 per copy with discounts for quantity purchases. Write to Publications Office, Group for the Advancement of Psychiatry, 419 Park Avenue South, New York City, 10016.

Governor Announces Six Committee Appointments

Governor Edgar D. Whitcomb recently announced appointments to six state groups, including the following physicians:

Hospital Licensing Council: **Drs. Hugh K. Thatcher, Indianapolis,** chairman; and **Kenneth E. Bobb, Seymour.**

Hearing Aid Dealer Advisory Committee: **Dr. Andrew C. Offutt, Indianapolis,** secretary (reappointment).

Indiana Tuberculosis Council: **Dr. Joseph M. Black, Seymour** (reappointment) and **Rex L. Thoman, Indianapolis.**

Indiana School for the Blind Advisory Committee: **Dr. Edwin A. Dyar, Indianapolis,** (reappointment).

Radiation Control Advisory Commission: **Drs. James C. Katterjohn, Indianapolis, and William D. Province, Franklin.**

Elkhart Physician Guest Speaker

Dr. Glenn Stoltzfus, Elkhart, pediatrician, was the guest speaker when the North Goshen Mennonite Women's Fellowship met recently.

Appointed Medical Director

Dr. John Bowman, Kokomo, has been appointed medical director of the new regional Comprehensive Mental Health Center at Howard Community Hospital, Kokomo. The center is to serve Tipton and Clinton counties, as well as Howard.

Dr. Scofield Keynote Speaker

Dr. John B. Scofield, Indianapolis, was the keynote speaker at the fourth statewide Gold Teen conference for mental health held recently at Indiana Central College, Indianapolis.

Dr. Paul Harris Retires

Dr. Paul N. Harris, Indianapolis, who has been associated with Eli Lilly for almost 34 years, has retired. He was a research associate in the toxicology division and has been responsible for the pathological data on many drugs.

Pfizer Supports Lectureship

Pfizer, Inc., gave financial support to the lectureship of Dr. Walter H. Smartt, Chief, Division of Venereal Disease Control, Los Angeles County Health Department, before the 122nd Annual Convention of the Indiana State Medical Association. Dr. Smartt addressed the Section on Public Health and Preventive Medicine.

Dr. Frederick Green Appointed

Dr. Frederick C. Green, a native of Fort Wayne and a graduate of Indiana University School of Medicine, has been appointed associate chief of the Children's Bureau of the U.S. Department of Health, Education, and Welfare.

Addresses Scientific Session

Dr. Robert M. Reid, Columbus, addressed the third annual scientific session of the American Society for Advanced Medical Instrumentation recently in Memphis, Tenn.

Dr. Ben Crouse Speaker

Dr. Ben Crouse, Mulberry, was one of the leaders of a smoking withdrawal clinic at Evansville recently.

Hospital Appoints Director

St. Mary's Hospital, Evansville, has announced that **Dr. F. Minton Hartz** will join the hospital's administrative staff and assume new duties as head of the Department of Medical Affairs on April 1, 1972. He will retire from private practice on Dec. 31, 1971.

Participate in Coronary Care Program at Lafayette Hospital

Drs. Lindley H. Wagner, Lafayette, William C. Elliott, Indianapolis, and Richard M. Nay, Indianapolis, participated in a four-hour session on coronary care at St. Elizabeth Hospital, Lafayette, recently.

Sponsors of the session were the Tippecanoe County Heart Association and the medical education departments of St. Elizabeth and Lafayette Home Hospitals, in cooperation with the Indiana Academy of General Practice.

Essay Contest Announced

The American College of Chest Physicians announces the establishment of the 1972 Alfred A. Richman Essay Contest. It is designated to encourage undergraduate medical students to explore and investigate problems relating to the disciplines of the chest. Research or review articles are eligible to compete. Preceptors are at liberty to assist the student in selecting a suitable subject and guide him in the preparation of the essay. Prizes of $500, $300 and $200 will be awarded.

Assist at Training Session

Drs. Daniel R. Evans, Valparaiso, and Firouz Farahmand, Portage, assisted at a training program for members of the Chesterton Junior Woman's Club who will be screening for amblyopia.

Dr. Lester Hoyt Speaks

"Can a Scientist Be a Christian?" was the topic chosen by **Dr. Lester Hoyt, Indianapolis,** for an address to the men's club of the Englewood Christian Church recently.

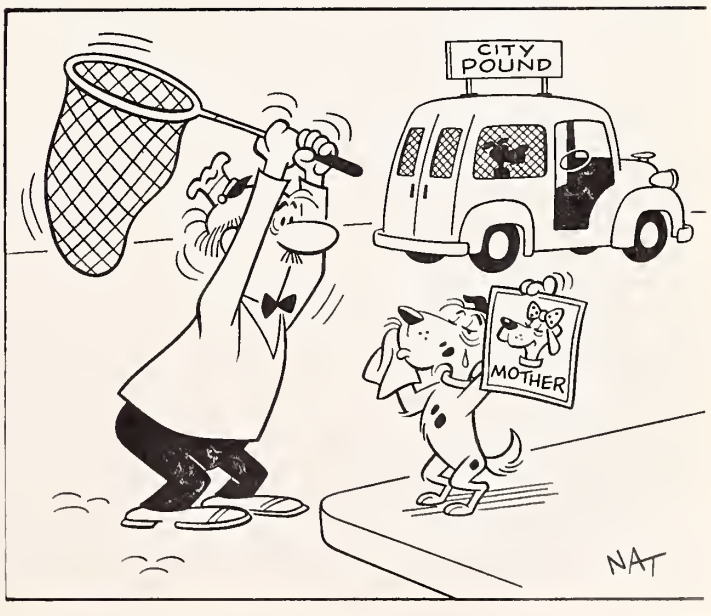
Paraplegia Foundation To Make Research Award

The National Paraplegia Foundation has established an award designated as the National Paraplegia Foundation's Basic Research Award. It includes a $10,000 honorarium and will be given to the scientist(s) of the world making the greatest contribution toward a cure for paraplegia.

Medical Library to Honor Memory of Dr. Ralph Dreyer

Announcement that Mrs. Mildred B. Dreyer had created a library and educational trust fund in memory of her late husband, **Ralph W. Dreyer, M.D., Richmond,** was made recently.

Dr. Dreyer was director of medical education at Reid Memorial Hospital, Richmond, prior to his death in the fall of 1970. Mrs.



Dreyer said her husband had expressed interest in the creation of a medical library at the hospital for some time prior to his death. The gift to the trust by his widow is designed to fulfill that wish.

The fund was established as an open-end fund with the Wayne-Union County Medical Society and the hospital announcing contributions in support of educational programs, the establishment of which are also included in the trust fund.

Phoenix Resort to Be Site of Fifteenth Cardiac Symposium

The Arizona Heart Association will conduct its 15th Annual Cardiac Symposium at the Mountain Shadows Resort Hotel in Phoenix on January 21 and 22, 1972. For full information write the Association at 1720 E. McDowell Road, Phoenix 85006.

50-Year Practitioner Honored

Dr. John Stanley Brown was the guest of honor at a recent dinner hosted by the Sullivan County Medical Society in commemoration of Dr. Brown's 50 years in the practice of medicine.

A resident of Sullivan, Dr. Brown continues to maintain his office and practice at Carlisle.

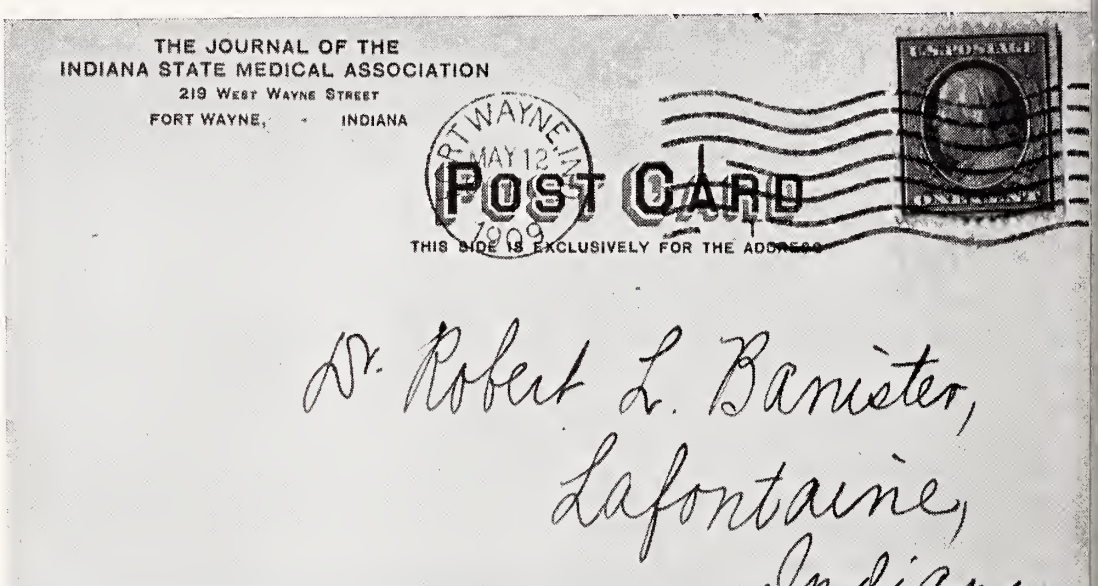
He has served as secretary of the county medical society for 49 years and has been secretary of the Second District medical society for 40 years.

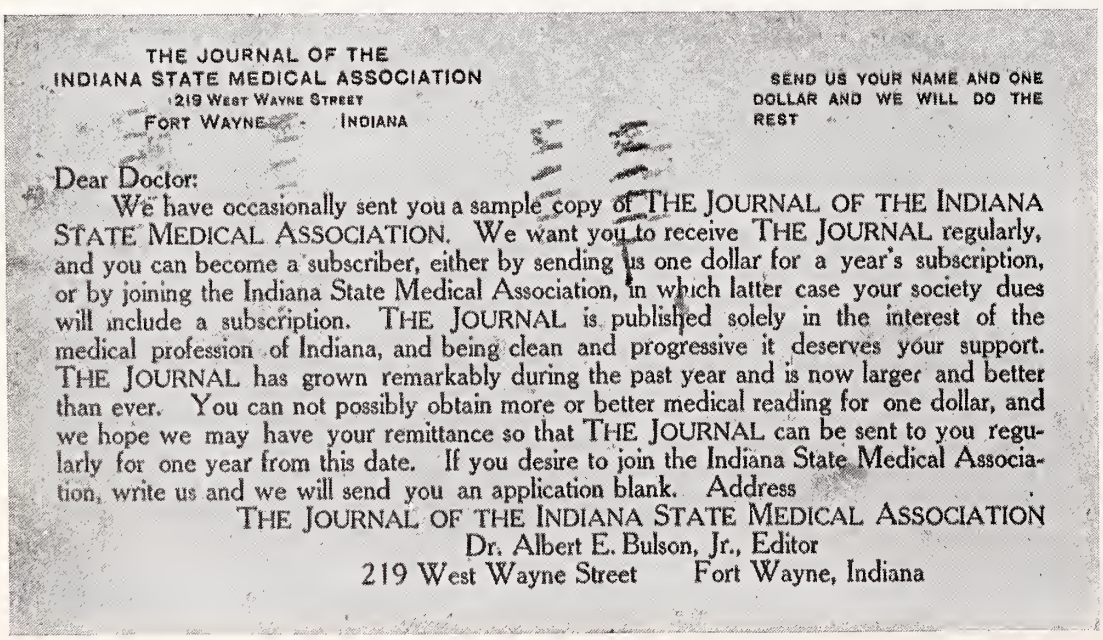
Dr. Irvin Scott, Sullivan, who served as master of ceremonies, pointed out that Dr. Brown was the ninth local physician who had been honored for 50 years of service.

Cancer Conference Scheduled

The Seventh National Cancer Conference will be held at the Biltmore Hotel, Los Angeles, September 27 to 29, 1972. The Conference is sponsored by the American Cancer Society and the National Cancer Institute. It meets every four years to provide a meeting place for cancer researchers and clinicians to review progress in treatment. All physicians are invited.

'Way Back When The Journal Was Two Years Old




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THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION
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Conducts TB Clinic

Dr. John D. Miller, Indianapolis, conducted a tuberculosis clinic in the Cass County health office recently. For doctor referrals only, the clinic was held on a Saturday afternoon and was limited to residents of Cass County although it is planned to open future clinics to residents of surrounding counties.

Dr. Popplewell Aids UF

Dr. Arvine G. Popplewell, superintendent and director of General Hospital, Indianapolis, will direct solicitations among physicians in the United Fund campaign in the Marion County area.

Receives "Outstanding" Award

Dr. William D. Pletcher, Elkhart, received an award for outstanding service to the American Cancer Society at a recent meeting in Goshen. He is a former president of the Elkhart County group.

Dr. Liddell Speaks to Nurses

Dr. Charles K. Liddell, Michigan City, spoke at the first of a series of monthly meetings for the nursing staffs of all three Michigan City hospitals. His topic at the September meeting was: "Abdominal Aortic Aneurysms—Surgery and Nursing Care."

Dr. Crockett Named to Board

Dr. Wayne Crockett, Terre Haute, is one of the four persons selected to serve as an advisory board for the Drug Crisis Center at Terre Haute.

Dr. Tucker Conducts TB Clinic

Dr. Warren Tucker, Indianapolis, was in charge of a recent diagnostic chest clinic sponsored by the Clinton County Tuberculosis Association.

Attends Ohio State Meeting

Dr. Roger Frazier, Hartford City, attended a two-day symposium at the Ohio State University Medical School last month. The symposium was on the diagnosis and treatment of vascular diseases and circulatory disorders.

Dr. Hutto Retires to Michigan

Dr. William Harry Hutto, a Kokomo physician and surgeon for 30 years, and Mrs. Hutto moved recently from Kokomo to Burt Lake, Mich., where they built a new home.

A former president of the Howard County Medical Society, he had served two terms as prseident of the medical staff of St. Joseph Memorial Hospital, two terms as the hospital's chief of obstetrics and was also its chief of surgery at one time. During World War II he served with the U. S. Air Force. ◄



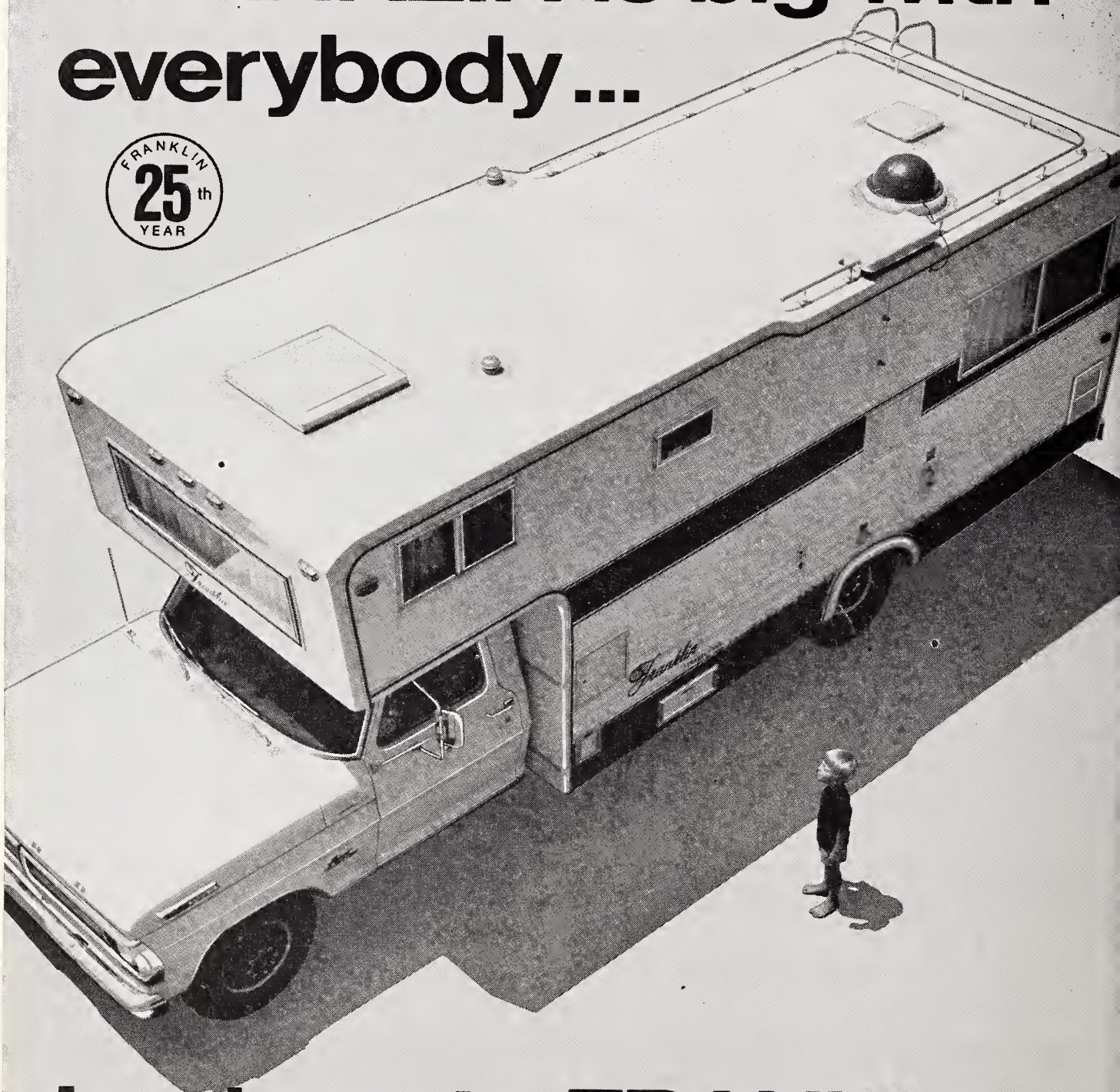
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New Blue Shield Facilities, Reorganization Assure Improved Physician Inquiry Service

A combination of new facilities and reorganization has been responsible for improvements in service by the staff of Blue Shield Internal Operations physician inquiry consultants.

"We have improved our service over the last couple of years and we're getting information out more accurately and quickly," states Office Supervisor David Widdifield concerning changes in his staff's operation.

And he adds, "We will be able to achieve even better results now that we're in the new building with new facilities." The internal office staff moved into the new Blue Cross and Blue Shield Service Center at 120 W. Market St., Indianapolis, the latter part of September.

Located on the 13th floor of the Service Center, the staff now has new visual display equipment to recall information instantly, speeding up service to physicians and other providers.

A big step in upgrading the efficiency of the inquiry operation resulted from a recent reorganization of office procedure. Consultants handling inquiries have been assigned to four specific areas of the state, each one served by a field representative in the same location.

The physician inquiry consultant has been recognized as holding one of the most responsible positions within Blue Shield.

Mr. Widdifield is a graduate of Ball State University with a B.S. degree in English and psychology. He was a teacher and coached football and wrestling at Union City and Northview Junior High School before coming to Blue Shield.

Five of the consultants handle phone inquiries from the four areas of the state.

Karell Taylor, who joined the staff only three months ago, is assigned the northeast portion of the state. She has been a Blue Shield employee five years, working previously in Medicare and Medicaid. Karell is a graduate of Indianapolis Tech High School.

Sharon Bringman, another Indianapolis Tech graduate and who received a B.S. degree in social studies from Indiana State, is responsible for the southern district. Sharon has been with the inquiry staff one year.

Vikkie Tucker handles inquiries from the central section of the state. A graduate of Shortridge High School in Indianapolis, she attended Indiana Central College and Indiana State University before joining Blue Shield two years ago.

Janet Huard, with Blue Shield the past 21 months, is accountable for the northwestern part of Indiana. She is a transplanted Buckeye from Pioneer, Ohio, with a B.A. in sociology from Bowling Green University.

Senior consultant on the staff of telephone correspondents is Elaine Glanzman. A graduate of Broad Ripple High School, she attended Ball State University. Elaine has been with Blue Shield for five years.

Three of the office inquiry consultants specialize in answering correspondence from physicians.

Grace Wollersheim is assigned the central Indiana district. She comes to Indiana from Wisconsin and is a native of Two Rivers. A graduate of Lincoln High School in Manitowoc, Wis., Grace attended the University of Wisconsin before coming to Blue Shield 18 months ago.

Claudia Bohard, who has been a Blue Shield employee for the past year and a half, handles inquiries from the northwestern district. A graduate of North Central High School in Indianapolis, she attended Indiana University.

Sylvia Dozier, a graduate of Indianapolis Shortridge, has both the northeastern and southern areas. She joined the staff of consultants this spring, but has been with Blue Shield four years, previously operating a transcriber unit.

Juanita Matthias is a clerk-typist for the staff of inquiry consultants. She is a Ben Davis High School graduate. ◄



PHYSICIAN INQUIRY STAFF—Shown above are members of the Physician Inquiry Staff of Blue Shield Professional Relations. Seated (left to right) are: Karell Taylor, Juanita Matthias and Sylvia Dozier; Standing are: Supervisor David Widdifield, Vikkie Tucker, Janet Huard, Claudia Bohard, Grace Wollersheim, Sharon Bringman and Elaine Glanzman.

WANTED: Physicians Locations

GENERAL PRACTICE

Clary, James K., 210 Donnelly St., Mountain City, Tenn. 37683

Laygo, Romualdo M., 28-14 Brookhaven Ave., Far Rockaway, N.Y. 11691

Liao, Schue-Yuan, 507 Hawkeye Court, Iowa City, Iowa 52240

O'Connor, Michael F., 15520 Windmill Pointe Dr., Grosse Pointe Park, Mich. 48230

Savinsky, Kenneth A., 18 Palisade Ave., Apt. 13B, Staten Island, N. Y. 38104

GENERAL SURGERY

Aguam, Abul S., 8945 134th St., Jamaica, N.Y. 11418

Aquino, Calixto F., 1505 Rockford Ct., Charleston, W. Va. 25304

Brenner, Hugo Antonio, 4014 Wimpole Rd., Louisville, Ky. 40220

Carroll, Charles P., Virginia Village, 5011 Caryn Court, Apt. 303, Alexandria, Va. 22312

Chanco, Jr., Amado G., Department of Surgery, University of Iowa Hospital, Iowa City, Iowa 52240

Daftarian, M., Medical College of Georgia, Eugene Talmadge Memorial Hospital, Augusta, Ga. 30902

Koa, Elpidio Y., 1917 Warwick Ave., Whiting, Ind. 46394

Novilla, Manuel R., % Factory Hospital, 4913 St. Clair Ave., Cleveland, Ohio 44103

Nowsatka, Raymond Robert, 2140 Brooks Dr., Apt. 719, Suitland, Md. 20028

Patel, A. K., P.O. Box 70, Inverness, Nova Scotia, Canada

Pugeda, Faustino V., 841 Mulberry, Williamson, W. Va. 25661

Singla, Sukldev Rai, VA Center, 4100 W. Third St., Dayton, Ohio 45428

Shinghal, P., 115 Town Square Drive, Newport News, Va. 23607

Steinbrecher, Leroy M. H., Private Bag 11 XC, Choma, Zambia, Africa

Sundaram, Shanmugha K., 841 S. Main Ave., Kankakee, Ill. 60901

DERMATOLOGY

Rogers, Roy Steele, III, 2706 Sarah Ave., Durham, N.C. 27707

Rasheed, Ahmed, P.O. Box 6998, Chicago, Ill. 60680

INTERNAL MEDICINE

Erxleben, Walter O., Jr., 2471 Normandy Dr. S.E., Grand Rapids, Mich. 49506

Kozul, Vlado J., 890 SOM Center Rd., Cleveland, Ohio 44143

Lazo, Benjamin G., 5269 E. 126th St., Garfield Heights, Ohio 44125

Magalong, Victor Mendoza, 316 Shipley Rd., Apt. 401, Wilmington, Del. 19809

Smith, Jon Thomas, 365 Arlinton Ave., Elmhurst, Ill. 60126

Spring, Donald Arthur, 3304 Hedden Rd., Apt. 3, Middleton, Wis. 53562

Srivastava, S. P., 730 Colony Court, Apt. 5, Niles, Mich. 49120

Szabo, Andrew John, 1249 Fifth Ave., New York, N.Y. 10029

NEUROSURGERY

Yballe, Danilo N. 4510 65th St., Sacramento, Calif., 95820

OBSTETRICS & GYNECOLOGY

Bhattacharyya, Benoyendu, 5470 Bessborough, Apt. 14, Montreal 265, P.Q., Canada

Bhupathy, Vellore, 802 Gaston Ave., Fairmont, W. Va. 26554

Choi, Duck-Joon, 3097 Valley Meadow Drive, Dallas, Texas 75220

Novak, Gary Arlen, 3933 Harvard, Detroit, Mich. 48224

Oh, Shi-Han, 13-C Concord Cove Apts., Havre de Grace, Md. 21078

Rivera, Victor M., 1274 Chesterdale Drive "E", Cincinnati, Ohio 45246

Zamora, P. E., D-6, Urb. Garcia-Ponce, Fajardo, Puerto Rico 00648

ORTHOPEDICS

Choi, Sung Duk, 719 Lewis St., Havre de Grace, Md. 21078

Coombes, Wilfred N., 635 Baywood St., North Bay, Ontario, Canada

Marshall, Cyril E., 2662 East Boulevard, Cleveland, Ohio 44104

PATHOLOGY

Agarwal, Prahladkumar Jivanlall, 2931½ Northview Blvd., Youngstown, Ohio 44504

Faustino, Benigno D., 527 35th St., Apt. 5, Des Moines, Iowa 50312

Lee, Jung K., 75 Beaumont Circle, Yonkers, N.Y. 10710

Rogers, Wallace A., Jr., Pathology, Med. Alumni, Burlington, Vt. 05401

Weaver, James M., 7213 Beechwood Rd., Alexandria, Va. 22307

PEDIATRICS

Bhupathy, Kalavathi, 802 Gaston Ave., Fairmont, W. Va. 26554

Chy-Koa, Leticia K., 1917 Warwick Ave., Whiting, Ind. 46394

Co, Teddy G., University Hospital, Edmonton, Alberta, Canada

Go, Gloria T., % Plantation Manor, Apt. 63, Charlotte Amalie, St. Thomas, U.S. Virgin Islands 00801

Gould, Stanley, 5 Edith Court, Wayne, N.J. 07470

Sundaram, Padma, 841 South Main Avenue, Kankakee, Ill. 60901

PSYCHIATRY

Rowan, Edward Leslie, 224 Ocean Rd., Greenland, N.H. 03840

RADIOLOGY

Esguerra, Jorge V., 158 E. 46th St., Brooklyn, N.Y. 11203

Gates, Jon H., 654 Tanglewilde, Baldwin, Mo. 63011

Paradis, Milo R. V., 114 Overlook Dr., Pittsburgh (Mt. Lebanon), Pa. 15216

Thumasathit, Chote, 49 Glenside Ave., Buffalo, N.Y. 14223

Quinn, James Gilbert, 3718 Greenway Place, Shreveport, La. 71105

UROLOGY

Amin, Narayan R., 2250 S. 17th Ave., North Riverside, Ill. 60546

Kotha, Vijayasimha, 7925 Kingsley Rd., Apt. 1004, Montreal, Quebec, Canada

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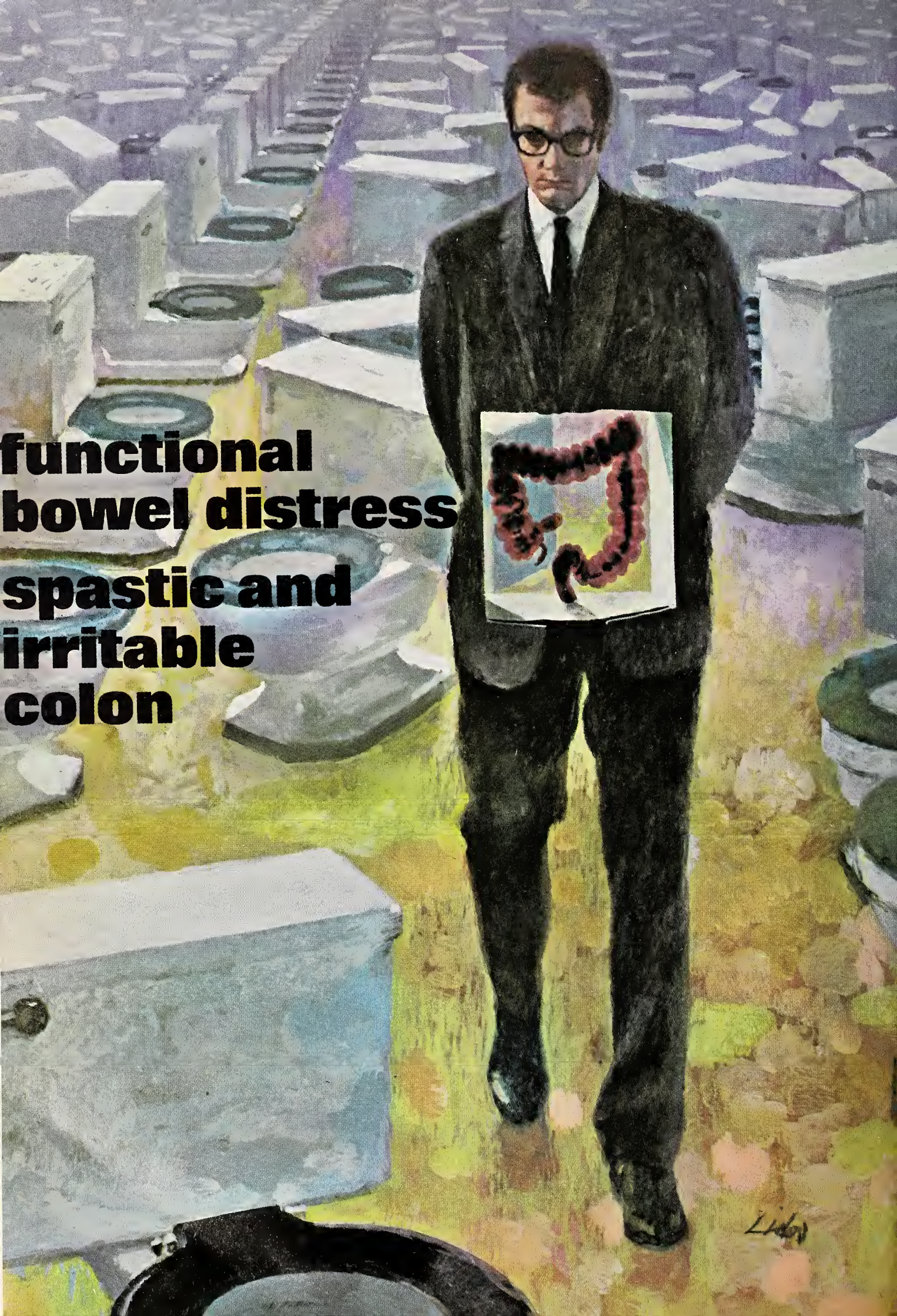


Additional information available to the profession on request.

Eli Lilly and Company • Indianapolis, Indiana 46206

Lilly

101488


functional
bowel distress
spastic and
irritable
colon

move up to "the Robinul response"

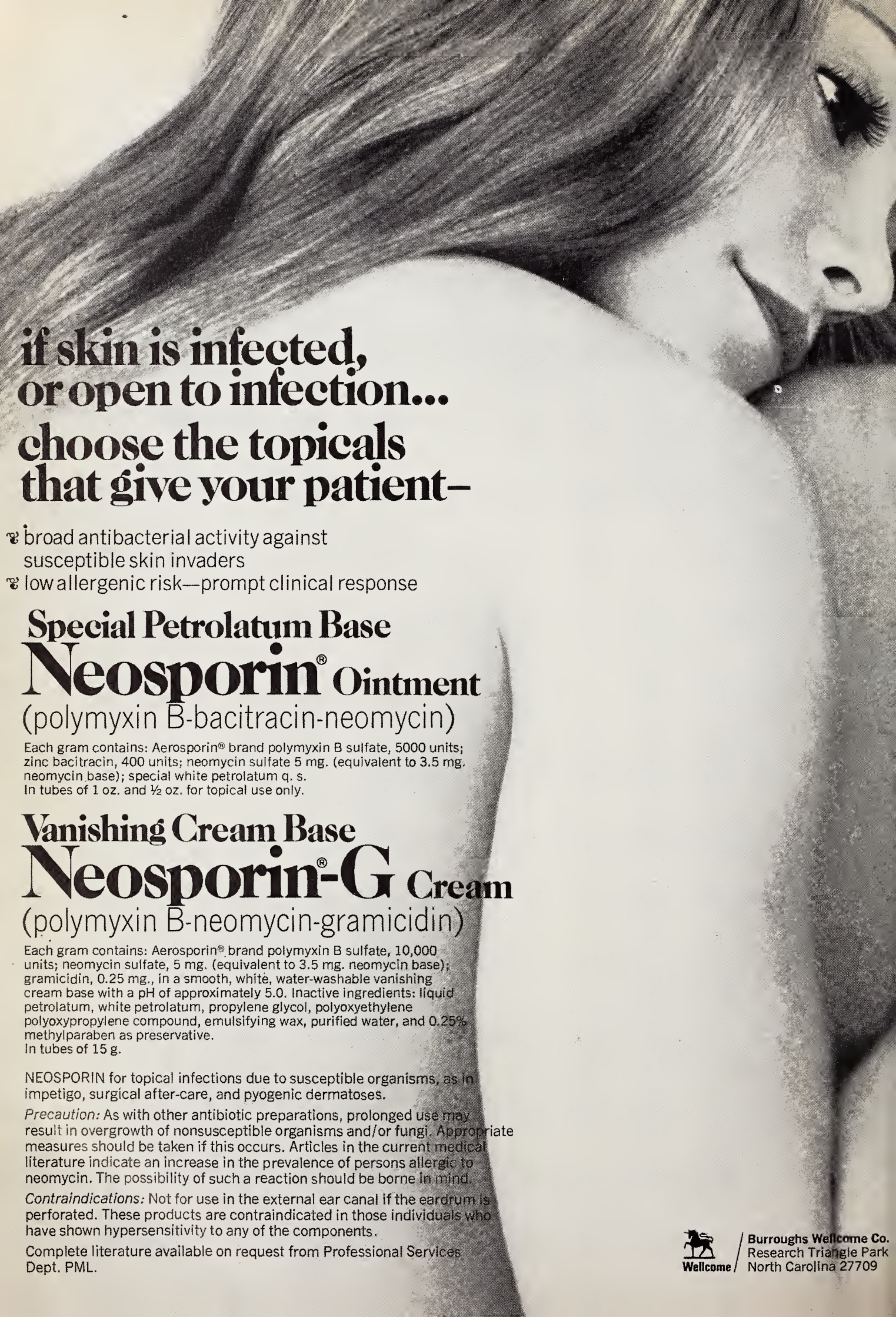
In treating hypermotility associated with functional lower G-I disorders are you disappointed in the results you've been getting with some of the synthetics? Then *move up* to a potent antispasmodic—Robinul® Forte (2 mg. glycopyrrolate). It provides prompt, pronounced, prolonged suppression of hypermotility, making it a highly effective agent in functional bowel distress, as well as in spastic and irritable colon. Robinul Forte also exerts a more selective action on the gastrointestinal tract. If the patient has a "one tract mind" concerning his lower G-I symptoms, you can help control the anxiety and tenseness by prescribing Robinul®-PH Forte (2 mg. glycopyrrolate with 16.2 mg. phenobarbital —warning: may be habit forming).

when lower G-I symptoms demand a potent synthetic antispasmodic

Robinul® 2 mg. Forte (glycopyrrolate)

■ **INDICATIONS** Robinul Forte (glycopyrrolate, 2 mg.) and Robinul-PH Forte are double-strength dosage forms of glycopyrrolate. They are primarily indicated for patients who are less responsive to anticholinergic therapy and for control of the more prominent symptomatology associated with acute episodes of gastrointestinal disorders. Emphasis should be on total management, with due consideration of the various therapeutic modalities available, including diet, antacids, anticholinergic agents, sedatives, and attention to emotional problems. Accordingly, glycopyrrolate is recommended in the management of gastrointestinal disorders amenable to anticholinergic therapy, such as: (1) duodenal ulcer, duodenitis, pylorospasm; (2) gastric ulcer, gastritis, esophageal hiatal hernia, hyperchlorhydria, pyrosis, aerophagia, gastroenteritis; (3) esophagitis; (4) cholecystitis, chronic pancreatitis; (5) spastic and irritable colon, ulcerative colitis, functional bowel distress, diverticulitis, acute enteritis, diarrhea; and (6) splenic flexure syndrome, neurogenic gastrointestinal disturbances. When these conditions are associated with psychic overlay, the formulation with phenobarbital may be indicated. ■ **CONTRAINDICATIONS** Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte (glycopyrrolate with phenobarbital), sensitivity to phenobarbital. ■ **PRECAUTIONS** Administer with caution in the presence of incipient glaucoma. ■ **SIDE EFFECTS** The most frequent side effect noted during clinical trials was dry mouth. Thirty-three (3.3%) of 1,009 patients receiving 1 to 32 mg. of glycopyrrolate a day complained of dry mouth of moderate to severe degree, but only 11 discontinued treatment because of this. Blurred vision, constipation, and urinary hesitancy have been reported infrequently. Other side effects associated with the use of anticholinergic drugs include: tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash. ■ **DOSAGE** The average and maximum recommended dose of Robinul Forte (glycopyrrolate, 2 mg.) or Robinul-PH Forte is one tablet three times daily (in the morning, early afternoon, and at bedtime). To obtain optimum results, dosage should be adjusted to the individual patient's response. After the more severe symptoms associated with acute conditions have subsided, the dose may be reduced to the minimum required to maintain symptomatic relief. ■ **SUPPLY** Robinul Forte (glycopyrrolate, 2 mg.) is available as scored, compressed pink tablets engraved AHR/2 in bottles of 100 and 500. ■ Robinul-PH Forte (glycopyrrolate, 2 mg., with phenobarbital, 16.2 mg.) is available as scored, compressed blue tablets engraved AHR/2 in bottles of 100 and 500.

A. H. Robins Company, Richmond, Va. A·H·ROBINS



if skin is infected, or open to infection...

choose the topicals that give your patient–

- broad antibacterial activity against susceptible skin invaders
- low allergenic risk—prompt clinical response

Special Petrolatum Base
Neosporin® Ointment
(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® brand polymyxin B sulfate, 5000 units; zinc bacitracin, 400 units; neomycin sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q. s.
In tubes of 1 oz. and ½ oz. for topical use only.

Vanishing Cream Base
Neosporin®-G Cream
(polymyxin B-neomycin-gramicidin)

Each gram contains: Aerosporin® brand polymyxin B sulfate, 10,000 units; neomycin sulfate, 5 mg. (equivalent to 3.5 mg. neomycin base); gramicidin, 0.25 mg., in a smooth, white, water-washable vanishing cream base with a pH of approximately 5.0. Inactive ingredients: liquid petrolatum, white petrolatum, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax, purified water, and 0.25% methylparaben as preservative.
In tubes of 15 g.

NEOSPORIN for topical infections due to susceptible organisms, as in impetigo, surgical after-care, and pyogenic dermatoses.

Precaution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: Not for use in the external ear canal if the eardrum is perforated. These products are contraindicated in those individuals who have shown hypersensitivity to any of the components.

Complete literature available on request from Professional Services Dept. PML.

Wellcome / **Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709

What's New?

Eli Lilly is reducing the prices on Pulvules and tablets of Ilosone and on tablets of Ilotycin. The new 500 mg tablets of Ilosone are included in the reduction.

* * *

The Benevolent and Necessary Institution is the title of a 360-page book by Eric Larrabee which details the origin and history of development of New York Hospital. Mr. Larrabee examines the institution's two centuries of existence and in the process records the growth of medicine, of medical education, of nursing education and the development of modern therapy. Doubleday has just released the book; price is $8.95.

* * *

The Travelers Insurance Companies announce a new non-cancellable disability income insurance plan for business and professional men. It is called the Select Circle Income Protector. It is guaranteed renewable to age 65, and to age 70, if the holder continues to work full time. Physicians are considered a preferred class.

* * *

The Trans Union Leasing Corporation of Chicago announces the availability of intensive care modular medical units which may be leased. These are self-contained, factory-built specialized care facilities which may be utilized as Coronary Care Units, or Medical or Surgical Intensive Care Units. There are also customized multiple-bed buildings. They are available in relatively short time and arrive completely built and ready to attach to existing hospital structures. They may be moved later in order to accommodate to changing plans. May be had with built-in air conditioning and humidity controls.

* * *

Posey, maker of a tremendous variety of hospital and medical care equipment, announces its new catalog with more than 200 items. It features BREEZELINE, a new dacron mesh, especially good for safety vests. Fifteen of the catalog items are new this year. The catalog is divided into nine product sections: (1) bed safety belts, (2) limb holders, (3) safety vests, (4) wheelchair safety products, (5) pediatric control products, (6) safety belts for guerneys, stretchers, and operating tables, (7) rehabilitation products, (8) orthopedic products and (9) miscellaneous.

* * * *

The Despatch Oven Company makes a hospital waste disposal system which has just been certified by the U.S. Environmental Protection Agency. It will handle paper, cloth, plastics, rubber, chemicals, pathological materials, dietary wastes and other hospital disposals. The incinerator is completely automatic and reduces gaseous exhaust to little but carbon dioxide and water. Small particles are washed away by water in the final wash stage.

* * * *

Bio-Derivatives has an economical new test called Bac-Detec/U, which, within two minutes and usually less, will enable physicians to routinely screen patients for bacterial infections of the urinary tract. It is not intended as a substitute for complete analysis but is, rather, a rapid screening test for office use. Positive tests should be sent for identification of the microorganism and a colony count.

* * * *

Posey is introducing its newest model of heel protector. It is called the "Swiss Cheese" Heel Protector because of its unique ventilating design. Fastens with a hook and eye fastener.

* * * *

Xerox is introducing wallet-sized EKG records to be carried by patients with significant cardiographic abnormalities. The cards are produced by use of the Xerox 7000 reduction duplicator. The idea is to help insure proper emergency treatment for heart patients and to help prevent overtreatment of emergency patients with other ailments.

* * * *

Preliminary work with a sustained-release form of L-dopa indicates that some of the side effects may be avoided. Blood level fluctuations are responsible for at least some of the undesired effects. The slow release form of the drug will also be of help to patients who are now required to take multiple doses—for some, as many as one dozen daily. The International Chemical & Nuclear Corporation markets L-dopa in the standard form and will continue investigation of the sustained-release type.

* * * *

The Helotie Company of Indianapolis has a new Narcotics Identification Guide developed specifically for teachers, ministers, parents and youth leaders. Drug information includes the jargon, physical symptoms, what to look for in a user, and the special dangers. Twenty different drugs are covered. The price is $1 per copy. The address is Box 18196, Indianapolis 46218.

* * * *

Data Display Systems announces a new technique for the rapid detection of occult coronary artery disease. The instrument is called the Omnicardiogram. It transforms ECG tracings to a form which permits the physician to readily detect coronary artery disease—even though it is otherwise masked within the normal bounds of the ECG. The OCG chart consists of an annular area bounded by two circles, one within the other and tangent at one point. An ECG transformation in a case free from coronary artery defects will produce a line which falls entirely within the area between the circles. Positive cases will be indicated by a line which falls outside the circles.

* * * *

Mead Johnson announces a 28-day sequential oral contraceptive, Oracon®-28. It consists of 16 white ethinyl estradiol, 0.1 mg tablets; 6 pink dimethisterone, 25 mg, and ethinyl estradiol, 0.1 tablets; and 6 green inert tablets.

* * *

What's New?

General Electric has a new light-weight lead apron for radiology staff use. Called FLIP-SHIELD™, the apron weighs only 8½ lbs, yet provides 0.5 mm pb. equivalent protection at 85kVp. The apron features 4-ply leaded vinyl construction covered on both sides with fabric reinforced white vinyl.

* * * *

Posey announces a pediatric deluxe limb holder. It is comfortable for the child since it will not tighten or loosen. Perfect fit is secured by Velcro closures. Long straps secure under the bed. The most active children may be held comfortably with complete security.

* * *

"Chemical Mutagens: Principles and Methods for Their Detection," a two-volume work edited by Dr. Alexander Hollaender and published by Plenum Publishing Corporation has been released for sale, at $17.50 per volume or $30.00 for the set. It offers a comprehensive account of chemical mutagens written by leading experts.

* * *

Stryker has a new all-purpose polyeurethane foam support for cradling and elevating arm or leg casts. It is ideal for supporting the patient's leg cast when he is placed in a wheelchair, and whenever elevation is needed.

* * *



"A TV survey, eh? No. I'm not watching my favorite program—but I am reading my favorite publication."

The Ames Company announces a new freezing microtome—a "second generation" model called the Ames ™Microtome-Cryostat, II. The instrument utilizes an inverted tissue freezing process which eliminates poor sections associated with high electrolyte concentrations. It has a fog-free window and a frost-free working area. Also automatic temperature controls and automatic defrosting.

* * *

The Pelouze Scale Company diabetic scale, the Pelouze YG-500, is becoming a home scale in addition to its functions in the past as a hospital scale. One of the large Indianapolis hospitals uses the scale in giving dietary instructions to patients and sells the same model if the patient wishes to take one home. It weighs accurately up to 500 grams in 1 gram increments.

* * *

Posey has a newly developed safety belt for chairs and wheelchairs. It is called the Posey Pelvic Seat. It is made of BREEZELINE material, nylon or cotton and consists essentially of a pair of boxer shorts with straps attached for purpose of security by tying around the back of the chair.

* * *

Nelkin Medical Products has an electronic transistorized sphygmomanometer called HEMO-SPHYG which will accurately determine blood pressure without the use of a stethoscope. A microphone in the arm cuff actuates a flashing red light for visual interpretation of the readings. It is more accurate than conventional methods because it eliminates errors due to hearing acuity, interpretation of sounds, and visual and auditory correlation.

* * *

There is a new pocket-size mini-recorder for up to 4 hours of electrocardiographic information. It is a miniature Holter recorder by Avionics Research Products. It will produce high fidelity, uninterrupted electrocardiograms on active, unsupervised subjects. The entire four hours can be analyzed in as little as four minutes when played back on the Avionics Dynamic Electrocardiographic System.

* * *

Container Development Corporation has a Plastibox® Bin System which provides an efficient method of handling and storing unit dose and multiple dose drugs in the hospital pharmacy. Plastibox Bins are one-piece thermoplastic molding which stack on each other. Each one has a hopper front and identification card holders. They are in a variety of sizes, styles and mounting configurations.

* * *

The lymphocyte is the arbiter of immunologic processes and as such is useful in pure form in many investigative forms. Technicon announces a Lymphocyte Separator. It takes advantage of the fact that a chemical reagent containing magnetic particles, when added to whole blood, sediments the red cells and renders all white cells, except lymphocytes, magnetic. The red cells are centrifuged out and the supernatent when passed

through a magnetic aperture will leave all non-lymphycytic white cells adhering to the apparatus and will contain lymphocytes almost in pure form. Lymphocyte purity averages 98%, cell viability approaches 100%. The apparatus is a closed, sterile system.

* * *

The Ames Company announces a new test for elevated urinary excretion of acid mucopolysaccharides such as is seen in Hurler's Syndrome, Morquio-Ullrich Disease, Hunter's Syndrome and Sanfilippo Disease. The test strips are known as MPS™ Papers. Normal individuals excrete from 5 to 15 mg of MPS daily but in those with mucopolysaccharidoses excretion may rise to as much as 100 to 150 mg daily. Use of the papers is recommended for neonatal screening programs.

* * *

Technicon announces a fully automated microvolume system for complement fixation. Very sensitive and reliable. It is applicable to the detection of Australia antigen, and the diagnosis of mumps, amebiasis, histoplasmosis and brucellosis. Complement fixation, despite its reliability, has been difficult to apply to clinical situations because of the complexity of the manual method. The speed and convenience of the automatic method will make the technic available for easy use for routine screening.

* * *

Environmental Sciences Associates are introducing a system for detecting and measuring trace amounts of metals and other elements in air, water, soil, body fluids or tissue. The device utilizes a form of electrochemistry together with peripheral sensors and recorders for analyzing samples in hundreds of different forms. It is said to be 10,000 times as sensitive as any other method. It will measure the amount of lead in one puff of cigarette smoke.

* * * *

Paul S. Amidon & Associates publish a 24-page booklet for the indoctrination of children about to be hospitalized or studied at clinics. It is titled "Joey's Journey." It combines poetry, pictures and prose to explain the approaching medical experience. The pictures are suitable as coloring projects to entertain small patients in the doctor's office.

* * * *

Kleen Test Products Company introduces a disposable cover for intravenous arm boards. The cover is made of a non-woven material which is soft to the touch and is fully absorbent to protect against spills. It is fitted with two tie bands which secure the arm board and cover to the patient's arm.

* * * *

McNeil Laboratories announce an injectable form of HALDOL® (haloperidol). It may be administered intramuscularly and is said to be especially effective in the emergency control of the agitated, combative or paranoid patient. Also useful in the treatment of acute alcoholic brain syndrome. It is contraindicated in severe depression or coma.

* * * *

Smith Kline & French has placed 'Urispas' on national distribution following its introduction in New England, the Mid-Atlantic states and the Southeastern states. 'Urispas' (flavozate hydrochloride) is a prescription drug indicated for relief of symptoms associated with various urologic disorders. It counteracts smooth muscle spasm in the urinary tract. It is compatible with drugs used in urinary infections, but is contraindicated in obstructive disorders.

* * * *

Bausch and Lomb announces a new type of contact lens made from a hydrophilic plastic material which absorbs 38.6% of its wet weight. The trademark name is SOFLENS. Fitting and prescribing the SOFLENS is different from procedures used with hard contact lenses. Bausch and Lomb are conducting symposiums throughout the U.S. to introduce the lens.

* * * *

Dover Publications publishes coloring books of sufficient quality to attract and entertain both adults and children. "The Middle Ages" consist of more than 50 authentic woodcuts which illustrate how people lived, worked, and played long ago. "Antique Automobiles" contains 43 drawings of early classic cars. "Edward Lear's Nonsense" is a collection of limericks with Lear's black and white illustrations which were originally produced for coloring by the reader. "The Illuminated Alphabet" is obtained from medieval manuscripts. All are artistically valid; suitable for coloring by crayon, marking pens or water color.

* * * *

Wyeth Laboratories has a new infant formula which incorporates in its fat blend a newly hybridized safflower oil, high in oleic acid and low in poorly absorbed stearic and palmitic acids. It comes closer to human milk than any leading formula. The name is S-M-A improved.

* * * *

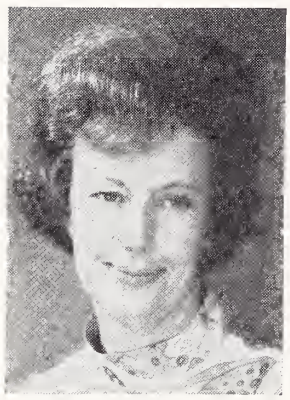
Mead Johnson is introducing a new product, SUSTACAL Nutritionally Complete Food, as a ready-to-use liquid and as a powder to mix with milk. It comes in two flavors, chocolate and vanilla. Three servings will provide all the Recommended Dietary Allowances of all vitamins and minerals, with the exception of magnesium, in the liquid preparation. Sustacal feedings may be oral or by a naso-gastric tube. ◄

About Our Cover

A billboard poster which was designed by Will Lamm, Indianapolis, State Board of Health illustrator, at the suggestion of Thomas Iozzo, Marion County Division of Public Health educator, and appeared in 10 locations in Indianapolis and on city buses, is reproduced on our cover. Naegele Outdoor Advertising Co. and Pfizer Laboratories contributed to the billboard project which was linked to Venereal Disease Control Week Oct. 17-23 in Indianapolis.

The Woman's Auxiliary

REPORTS TO ISMA



The guest writer this month is Mrs. Claude Meyer (Bonnie). She is young, vivacious, hard-working, the wife of a sports-loving, general practitioner and the mother of five children. She plays golf and tennis and skiis on water and snow.

In addition to all these activities, she finds time for church and the medical auxiliary.

This year, as the new AMA-ERF chairman, she is engaged in raising money for AMA-ERF. Everyone will want to help by buying Christmas cards and gifts from Bonnie. Here she is to tell you what AMA-ERF is and why your help is needed.

Lelia M. Chernisky

Auxiliary in Action for AMA-ERF

What is AMA-ERF? It was established January 1, 1962, by combining two previously established foundations: AMEF and AMRF, organizations which began approximately 10 years earlier. AMA-ERF seeks financial support from the nation's physicians, medical societies, the Women's Auxiliary to the American Medical Association, philanthropic organizations, business corporations and the general public.

The medical auxiliaries in the state of Indiana concentrate on fund-raising projects for student loans and funds for the medical schools. As you know, capable young people are being turned away from our medical schools because of inadequate facilities to handle them.

The cost of providing quality medical education is astronomical. Providing more physicians means providing better and larger facilities and additional equipment and hiring more faculty members. Most schools just don't have the funds to do this. Even schools with large endowment programs are facing financial belt-tightening, because their funds are often earmarked for special projects.

What is needed is flexible financial aid — the kind that AMA-ERF funds provide. Deans of medical schools receive AMA-ERF money without strings attached to use as they see fit to solve their most pressing financial problems.

Every auxiliary should have at least one fund-raising project to help raise the millions of additional dollars needed for medical schools and student loans. The most successful fund raiser year after year is Christmas cards. Another booster for AMA-ERF is notepaper and memorial cards; these are excellent profit makers.

The money collected in Indiana so far in 1971 has surpassed that raised last year by this time, and we know everyone is doing her best for the year 1972.

The money already is coming in steady,
So far we're ahead of last year.
So let no one shirk, keep up the good work,
In May we'll have reason to cheer.

Bonnie Meyer
(Mrs. Claude J. Meyer)
AMA-ERF Chairman

Deaths

Ezra D. Alexander, Sr., M.D.

Dr. Ezra D. Alexander, Sr., who had practiced medicine in Indianapolis for 51 years, died Sept. 29 in an Indianapolis hospital.

A member of the Marion County Medical Society, he became a member of the Indiana State Medical Association's Fifty-Year Club in 1969.

Lester Borough, M.D.

Dr. Lester D. Borough, 57, South Bend psychiatrist, died September 24 in Memorial Hospital there.

A graduate of the Indiana University School of Medicine, Dr. Borough was a charter member of the American Medical Electroencephalographic Association. In May of this year he was awarded a life Fellowship in psychiatry.

During World War II he served in the Army as chief of staff in psychiatry and neurology at Ft. Sill, Okla.

Robert F. Harris, M.D.

Dr. Robert F. Harris, Noblesville, died Oct. 6 in Methodist Hospital, Indianapolis. He was 68.

A native of Washington, D.C., he graduated from the Indiana University School of Medicine in 1927. A member of the Hamilton County Medical Society, he had served on the Indiana State Medical Association's Convention Arrangements Committee from 1960 to 1962 and as secretary of the committee in 1961.

He was a member of the Indiana Academy of General Practice and was serving as president of the Hamilton County Heart Association at the time of his death.

A. F. Gregoline, M.D.

Dr. Amadeo F. Gregoline, Lake County health commissioner since 1966, died October 6 in his home.

After graduation from the University of Illinois Medical School, Chicago, Dr. Gregoline practiced in Gary from 1933 to 1965, when he retired from private practice. He had served as a member of the Gary Board of Health and was a former deputy county coroner.

He was a member of the Lake County Medical Society.

Nelson H. Prentiss, M.D.

Dr. Nelson H. Prentiss, 73, formerly of Fort Wayne, died Oct. 2 in the Hines Veterans Administration Hospital, Chicago.

A native of Allen County, he was a practicing physician in Fort Wayne from 1928 to 1953 and later served as a staff physician at the V.A. Hospital, Oteen, N.C., for 15 years before retiring.

A senior member of the Indiana State Medical Association, he was also a member of the American Academy of Physical Medicine and Rehabilitation and was a veteran of World War. I.

Robert W. Viehe, M.D.

Dr. Robert W. Viehe, an Evansville physician for more than 50 years, died at Turtle Creek Convalescent Center September 3. He was 87.

He graduated from the University of Pennsylvania School of Medicine and returned to his home town, where he opened an office in 1910. When he retired in 1961, he had maintained his office at the same address for 51 years.

A senior member of the Indiana State Medical Association, he had served as president of the Vanderburgh County Medical Society and became a member of the 50-Year Club in 1957. ◄

Fat Labeling

FDA is taking major initiatives to improve nutritional labeling of food products. Some of these efforts are of particular interest to physicians.

Of most interest, perhaps, are proposed changes in fat labeling. FDA has proposed regulations requiring product labels to give the name, source, and amount of fat content, and, on some foods, the amount and kind of fatty acids present. Under this proposal, such uninformative labeling as "shortening" or "vegetable oil" would be stopped.

FDA is proposing the fat labeling regulations to provide information to interested consumers and their physicians. The Agency is not recommending changes in dietary habits; neither is it taking sides in any medical discussion.

A related step by FDA is designed to make it possible for buyers to determine from the label the nutritional value of the food he is buying.

Several types of labels are being tested to measure effectiveness from the consumer's point-of-view. From these tests should come necessary information to evaluate consumer understanding, acceptance, and use of nutrient labeling. —*FDA Drug Bulletin*, Oct. 1971.

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County, District News

Tenth District

Dr. Lambro Dimitroff, Calumet City, Ill., was re-elected president of the Tenth District Medical Society at the group's September 21 meeting.

Dr. Donald C. Miller, Cedar Lake, was elected secretary.

Eleventh District

Dr. John Elleman, Kokomo, is the new president of the Eleventh District Medical Society, while Dr. Fred Poehler, LaFontaine, will continue to serve as secretary.

Allen

The Fort Wayne-Allen County Medical Society heard a talk by Tibor J. Greenwalt, M.D., medical director of the American National Red Cross, on "Effective Utilization of Blood and the Hepatitis Problem" at their October 5 meeting.

Dearborn-Ohio

A talk on art appreciation was given by a Doctor Ibanez at the October meeting of the Dearborn-Ohio County Medical Society.

Floyd

Dr. Marshall H. Buchman, New Albany, has been elected president of the Floyd County Medical Society. Dr. Daniel Cannon, also of New Albany, will continue to serve as secretary.

LaGrange

Dr. Richard D. Willard, LaGrange, is the new secretary of the LaGrange County Medical Society. Dr. K. M. Lehman, Topeka, is president.

Marshall

"Hemorrhagic Shock" was the subject of the talk given by Dr. J. B. Collins, head of the department of anesthesiology, Cook County Hospital, Chicago, to members of the Marshall County Medical Society Oct. 5.

Wayne-Union

Forty-five members of the Wayne-Union County Medical Society attended the dinner meeting of the society September 14 at the Reid Memorial Hospital.

Trooper Steve Leverton from the Indiana State Police Connersville Post spoke on "Accident Investigation and Prevention."

The members voted to help establish and support a medical library and educational trust in honor of the late Dr. Ralph Dreyer.

NEW PROSTHETIC METHODS OPEN NEW DOORS

New doors have been opened to amputees — thanks to new prosthetic techniques. During the past few years many recent prosthetic developments now offer improved function for the amputee, as well as better appearance and increased comfort.

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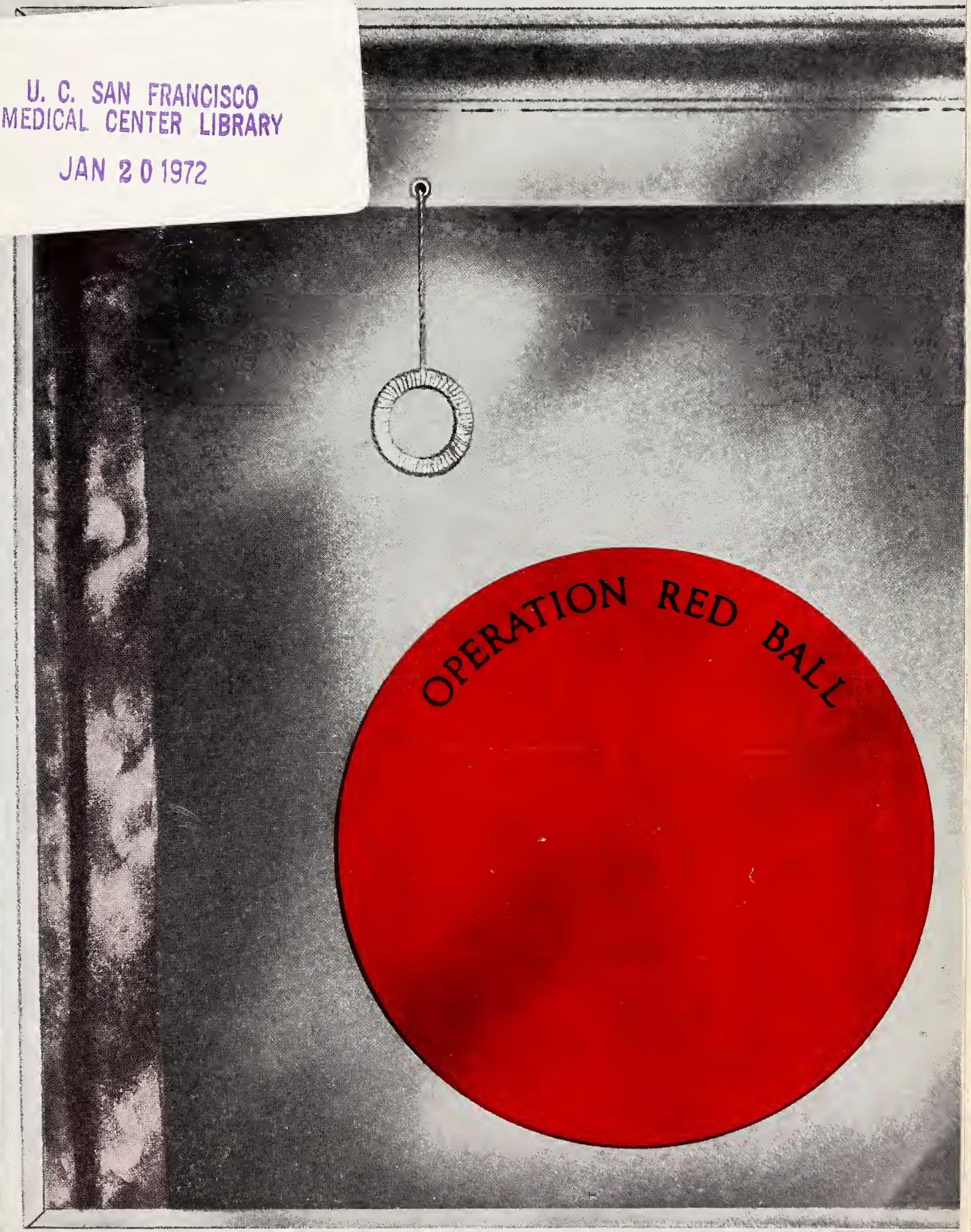
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Patients fell asleep quickly

Dalmane (flurazepam HCl) 30 mg reduced awake time—both before and after falling asleep - by fifty percent of pretreatment values in patients with insomnia.[1,2]

Two sleep laboratory studies recently confirmed findings of earlier studies of this type, namely, that Dalmane 30 mg was effective in patients who had trouble falling asleep, staying asleep or both. One 30-mg capsule of Dalmane usually induced sleep within 22 minutes, decreased the number of awakenings and the wake time after the onset of sleep, and provided 7 to 8 hours of sleep without need to repeat dosage during the night.

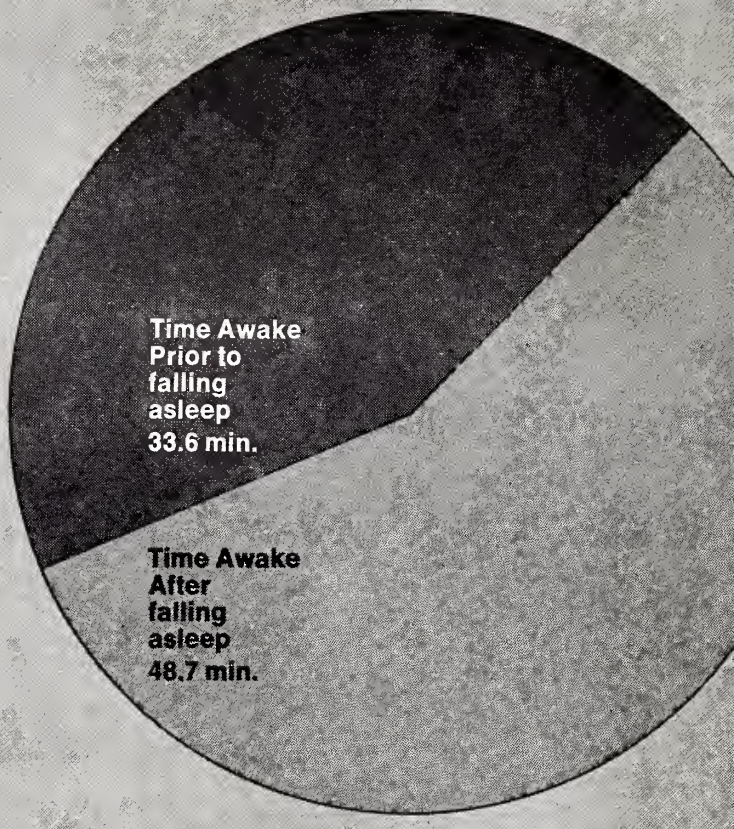
These studies utilized identical protocols and included eight insomniac patients. Sleep laboratory measurements in a limited number of patients are derived from all-night electro-encephalographic, electro-oculographic and electromyographic tracings. Unlike traditional methods of evaluation, they are quantitative, reproducible and projectable to large numbers of subjects.

Results shown represent average values in all subjects for the three consecutive nights of placebo administration prior to Dalmane therapy and the seven consecutive nights on Dalmane 30 mg.

Dalmane is also relatively safe, as reported in clinical studies. Instances of morning "hang-over" have been relatively infrequent; paradoxical reactions (excitement) and hypotension have been rare. Dizziness, drowsiness, lightheadedness and the like were the side effects noted most frequently, particularly in the elderly or debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

References: 1. Frost, J. D., Jr.: "A System for Automatically Analyzing Sleep," Scientific Exhibit presented at Clinical Convention, A.M.A., Boston, Nov. 29-Dec. 2, 1970, and Aerospace M.A., Houston, April 26-29, 1971.
2. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J.

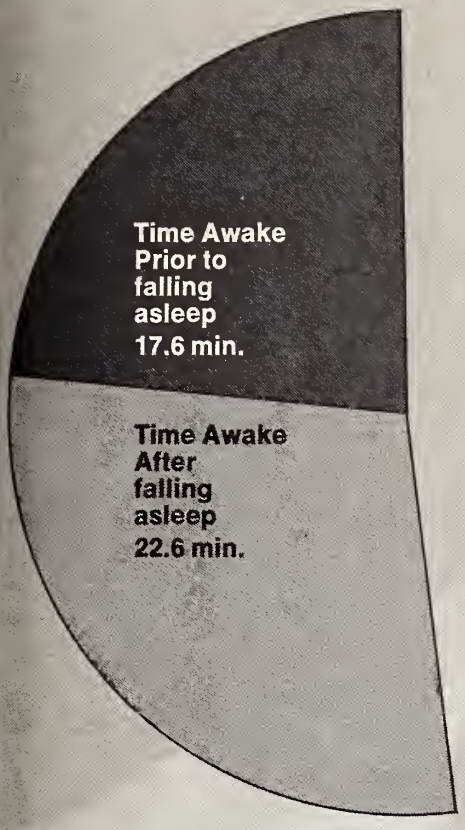
Before Dalmane (flurazepam HCl)



Measurements of sleep in the sleep laboratory are obtained with electroencephalographic, electro-oculographic and electromyographic recordings.

ıd slept through the night

On
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(flurazepam HCl)



age sleep laboratory measurements in cited studies

meter	Before Dalmane	On Dalmane
required to fall asleep	33.6 min.	17.6 min.
time after onset of sleep	48.7 min.	22.6 min.
ber of wakeful periods after set of sleep	12.2	8.4
sleep time	420.0 min.	447.5 min.
sleep percent	88.6	94.5

nical effectiveness as
oven in the sleep laboratory

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

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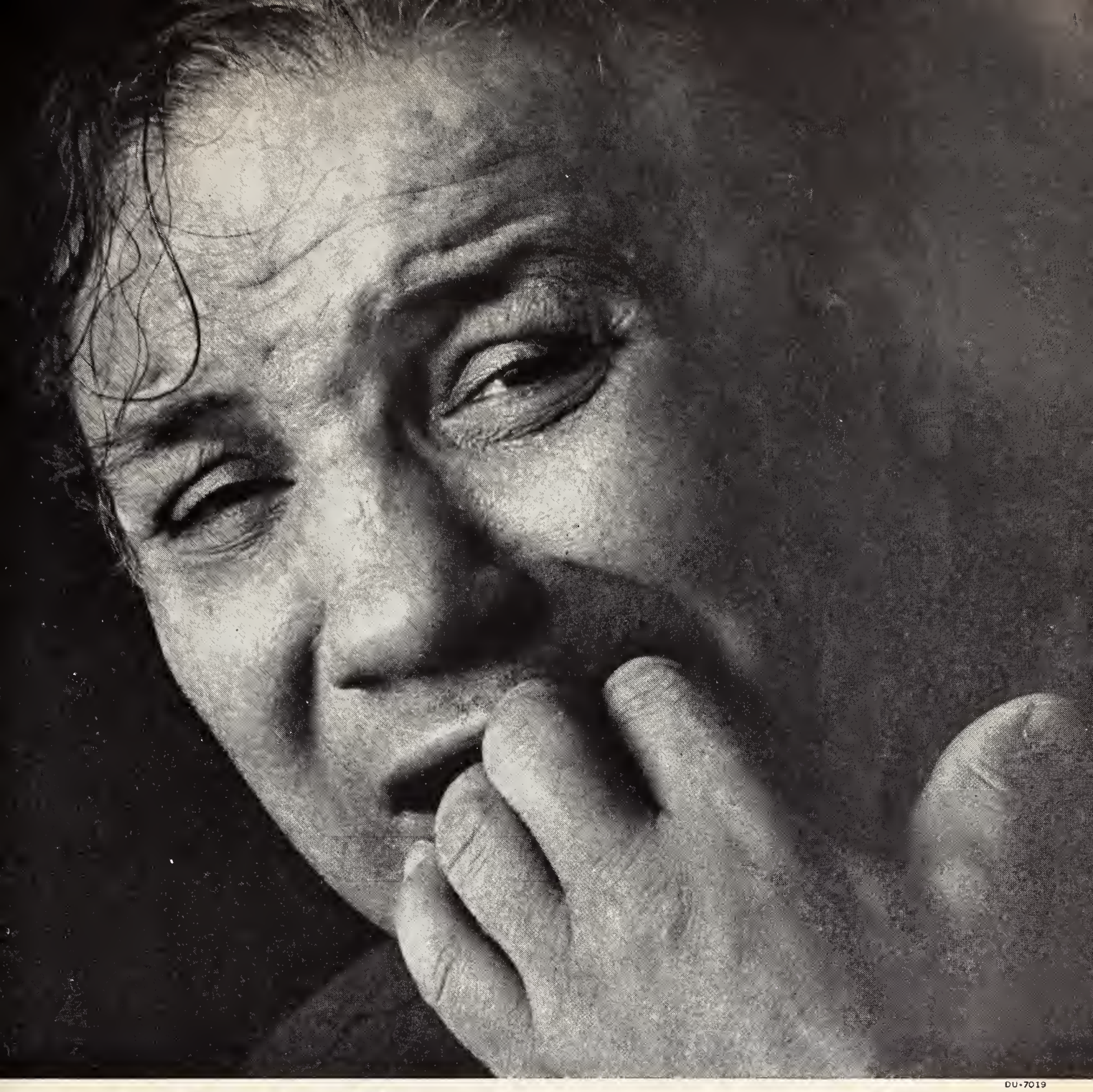
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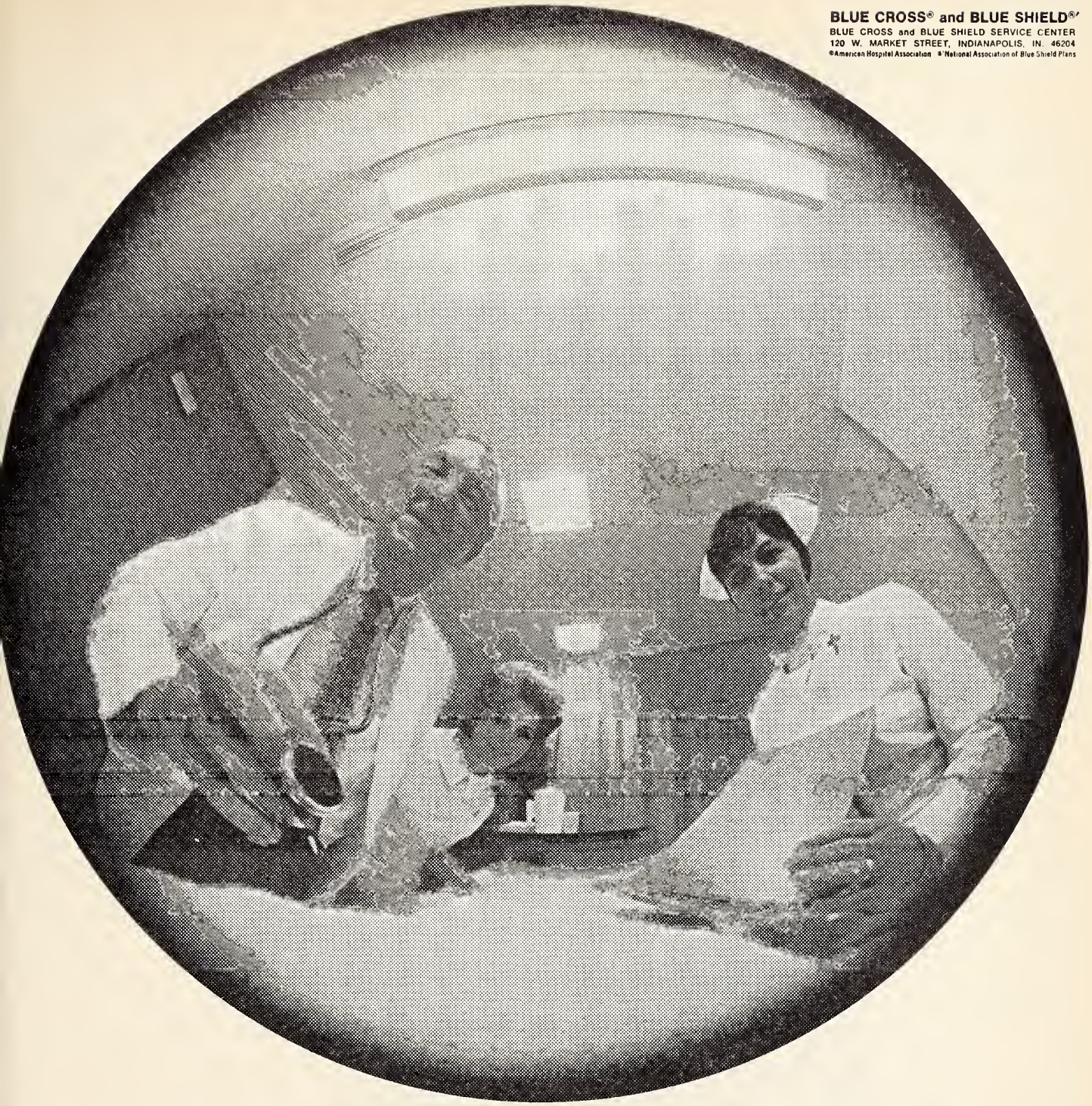
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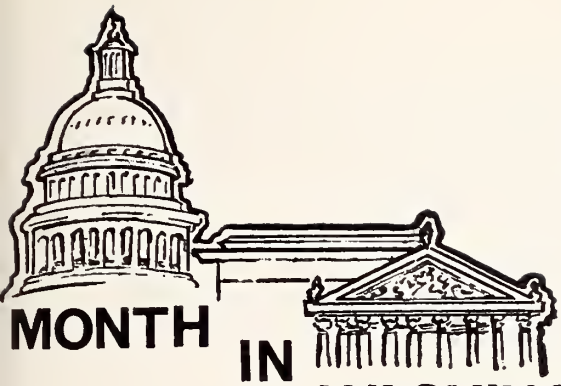
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MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the first of each month preceding month of issue.

THE LONG-AWAITED public hearings on the various proposals for national health insurance before the House Ways and Means Committee are now underway. Some 200 organizations and individuals are expected to testify during the scheduled six weeks of hearings.

LEAD-OFF WITNESS was HEW Secretary Elliot Richardson, who revealed an entirely new proposal "to tighten controls on provider costs and inefficiencies."

THE SECRETARY also outlined the long-awaited program for regulating private health insurance companies. In the 38-page statement, Richardson was highly critical of the Kennedy-Labor Bill.

RICHARDSON said the provider controls and the insurance company plan will be submitted in legislative detail to the Committee shortly.

FOLLOWING IS a summary of the Administration's text on the provider plan:

"IN ORDER TO help the consumer become a prudent buyer in the medical care market and to protect the consumer against unnecessary increases in health care costs, we shall propose the following provisions:

. . . The states shall require health insurance companies to inform prospective policyholders as to benefits, exclusions, premium costs and delivery system choices.

. . . The states shall require providers to inform the public as to charges for standard items and other patient access matters.

. . . We will establish on an experimental basis local quality review organizations composed of outside medical experts, including non-providers in some instances.

. . . We also propose to require NHISA carriers to apply control measures and statistical reporting measures in accordance with Federal guidelines, such as strict review of utilization of health care services. Specific plans for implementation with regard to wages and prices will be developed in conjunction with the Committee on the Health Industry established by the President under Phase II of his new economic policy.

. . . State planning agencies will be required in cooperation

Continued

with area-wide planning agencies and as a condition of Federal grant support and approval, to identify geographic areas of physician and facility oversupply. States are to develop and apply detailed criteria based on Federal guidelines, and publish this information.

UNDER THE PROPOSED insurance company regulations, Richardson said: "WE INTEND TO secure agreements with states under which the states will

- . . . Require annual, independent audits of participating insurance companies.
- . . . Create state health insurance insolvency mechanisms. A Federal mechanism will also be established for use if a state fails to act satisfactorily.
- . . . 'File and use' procedures for premium rates under NHISA insurance contracts, with authority to disapprove extra-ordinary rates.
- . . . Require disclosure by insurers of their administrative expenses as a percentage of premiums.
- . . . Create state insurance pools, on a statewide or substate basis open to small employers, the self-employed, and those who are not employed but are ineligible for Federally-financed health programs."

RICHARDSON SAID he was certain the hearings "will culminate in a national health insurance program." The Administration's plan avoids the danger of two extremes—proposals that do little to alter the present system and proposals to substitute a monolithic Federal scheme, he declared. Richardson said proponents of the Kennedy-Labor Bill "seem to assume that radical intervention by the Federal Government in health care, in an inflexible, predetermined and monolithic manner, is the only way to solve health organization and delivery problems. I suggest that we are more likely to attain our common health objectives by stimulating competition and by promoting consumer education and freedom of individual choice, rather than by resorting to fiscal coercion and unrealistically global schemes." He estimated it will cost $60 billion in new taxes.

THE AMERICAN Medical Association's "Medicredit" and the Health Insurance Association of America's plan also were criticized. The major shortcoming in both, said Richardson, "is the great unlikelihood of achieving universality in protection."

THE CATASTROPHIC protection plans, standing alone, "do very little for very few people—far less than what this nation must do if it is to act with a full sense of responsibility," the HEW Secretary testified.

MILLS OPENED the hearings by noting that health providers are beset by many problems. High quality care is available but unevenly distributed, he said, and costs are rising; there is lack of planning; the nation depends on importing foreign graduates; and consumers often find care difficult to get.

WITH THE Administration's testimony in hand, the Committee then turned to the long parade of witnesses from such diverse organizations as the College Democratic Clubs of America to the Senior Citizens Golden Ring Council to ascertain how they think the nation's health care system should be reshaped.

AFL-CIO PRESIDENT Meany told Committee members that "Labor will vigorously oppose"

any efforts to dilute its plan for national health insurance.

"I HOPE and firmly believe that we won't have to come back in the next Congress," Meany said. "But, if we have to, we will come back again and again until the Health Security Program is enacted. And, if we have to, we will take this issue to the people in the elections of 1972."

MEANY BLASTED the national health insurance proposals of the Administration, the health insurance industry, and the AMA—saying they "would all just pour new money into the present health care delivery system which is a failure."

HE SAID THAT AMA's Medicredit "represents a major shift in direction for organized medicine . . . but it is little more than a continuation of the present unsatisfactory system of delivering health care.

MEANY SCOFFED at warnings that physicians might rebel if the labor bill is enacted. "The vast majority of doctors are dedicated, proud professionals whose basic concern is for the sick and ailing."

COMMITTEE MEMBER Hugh L. Carey (D., N.Y.), told the labor witnesses when the committee meets in executive session it must face the fiscal considerations involved and try to develop a measure that fits within some dollar figure. He asked whether labor would be willing to make a choice between comprehensive coverage for part of the population or basic coverage for all. A labor witness replied to the effect labor does not want to make such a choice now. "We will cross that bridge when we get to it."

THE AMERICAN FARM Bureau Federation urged caution against the creation of "a powerful bureaucracy of great scope" and the National Federation of Independent Business came out flatly against any compulsory insurance system.

THE AMERICAN Public Health Association called for a broad national program with heavy emphasis on speeding development of prepaid group plans. The goals set forth by James Kimmey, APHA Executive Director, fit the labor bill more than any other proposal, but the association did not endorse a single measure.

EQUITABLE LIFE Assurance Society President, J. Henry Smith, accompanied by Daniel Pettengill and Ardell T. Everett, presented the combined statement of the Health Insurance Association of America, American Life Convention, Life Insurance Association of America and Life Insurers Conference.

SMITH URGED enactment of "The National Health Care Act of 1971," the insurance companies' plan, under which federal standards would be set for insurance coverage, personal and corporate income tax incentives would encourage participation, and federal-state subsidies would finance coverage for the indigent and medically indigent as well as uninsurable persons with sliding scale contributions for premiums.

COMPREHENSIVE health insurance should be available to all, Smith said. "This can best be achieved at lowest cost and most rapidly by expanding the scope of existing health insurance plans . . . for those without resources, governmental subsidies are required."

"THE CHOICE BETWEEN a pluralistic private insuring mechanism and a monolithic federal one is a fundamental choice that must be made before any national

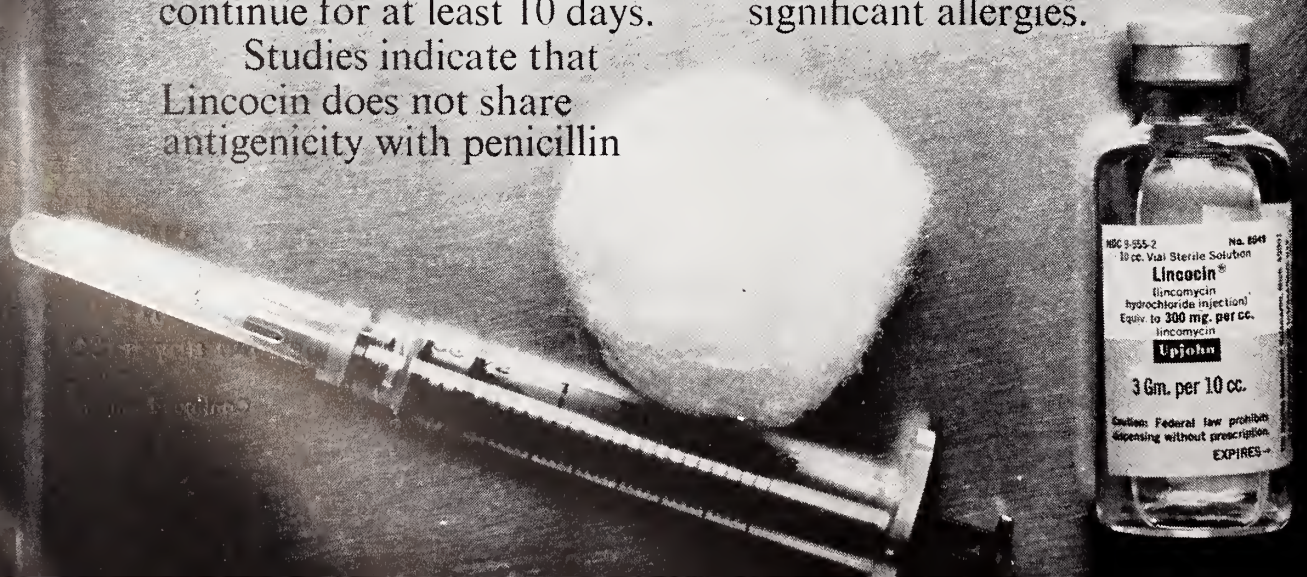
Continued on page 1273

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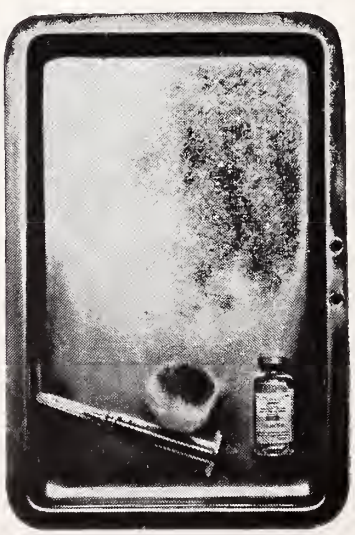
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PRECAUTIONS: Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of β-hemolytic streptococci infection for ten days to diminish likelihood of rheumatic fever or glomerulonephritis.

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health insurance plan can be adopted. We think our record of accomplishments is good and our potential is great."

REPLYING TO CHARGES private companies have failed to stem rising costs, Smith said the principal causes have been rising wages, more costly equipment and expensive new life-saving techniques. He asked whether insurers were supposed to prevent these developments.

FURTHERMORE, the witness said, "insurers have tried hard to spot and control overcharging. We have worked with medical societies to set up peer review committees, not just for the purpose of catching overcharges, but for the purpose of educating physicians not to overcharge in the first place."

THE NATIONAL Association of Insurance Commissioners urged preservation and expansion of the existing system of private health insurance and recommended utilization of the state insurance regulatory mechanism rather than a new federal one.

"THE ABANDONMENT of the extensive system of private health insurance in favor of an all-government program would reject decades of expanding and improving an on-going system and would cause severe dislocation in both state and federal revenues," said Russell van Hooser, Insurance Commissioner of Michigan.

THE INTERNATIONAL Association of Health Underwriters "wholeheartedly" supported the Private Insurance Company Bill.

THE AMERICAN Dental Association said any National Health Program should start out with a dental component that concentrates on preventive services for children. Any program approved should include dental benefits. The same stand was taken by the American Society of Oral Surgeons.

LEONARD WOODCOCK, President of the United Auto Workers Union, told the Committee "it is time to cancel the insurance industry" and impose a national health insurance program operated by the government.

WOODCOCK OPPOSED the Administration's proposal to require employers to provide employees with health insurance from private firms, saying organized labor helped to create the private health insurance industry, and supported it for three decades.

"BUT THE PRIVATE health insurance industry has failed," Woodcock said. "It has failed to control costs. It has failed to provide adequate benefits even for those with some form of coverage. After 30 years of effort, all private health insurance combined still covers only a little more than one-third of private personal health care expenses."

WOODCOCK SAID the Nixon plan would not regulate the insurance industry although it would require purchase of $30 billion of private insurance.

"IT IS TIME to cancel an insurance industry that places a premium on sickness rather than health and that puts the interests of consumers last in line," Woodcock said.

PHARMACISTS represented by the American Pharmaceutical Association urged the Committee to include drugs in any health insurance plan. The Committee is not expected to act on health insurance legislation until next year.

WILLIAM G. BATTAILE, president of the American Association of Blood Banks, asked that no coverage be provided to pay for blood transfusions. He contended that payments would encourage greater use of commercial blood banks and increase the risk of hepatitis.

Continued

AT THE END of the second week Ways and Means Chairman Wilbur Mills had attended only one of the hearings and other committee members seemed to be platooning themselves in the arduous task of listening to the opinions of so many diverse organizations and individuals.

EXPECTED to be signed into law shortly is health manpower legislation that will authorize an estimated $2.9 billion in aid to health profession students and their schools in the next three years—and provide the facilities and programs to close the manpower shortages in the health professions within seven years.

MEDICAL SCHOOLS would receive $11,500 for the full-term cost of training each student. Each school would receive $2,500 per student per year for the first three years of training. The grant rises to $4,000 for the year of graduation. In order to encourage swifter training, three-year schools would receive $13,500 based on $2,500 for each of the first two years and $8,500 for the third year.

EACH SCHOOL WOULD be required to enroll an additional five per cent of students, or five students (whichever is the greater) to qualify for assistance. An extra $1,000 a year would be awarded schools for each student exceeding this total. The legislation will also help establish at least five new medical colleges.

ADDITIONAL authorizations would provide $270 million for health manpower education initiative awards to alleviate manpower shortages and to train new types of personnel, and $412 million for special project grants for programs in family medicine, physician assistant training and others. The bill continues support for scholarship and student loans at increased levels, as has been provided heretofore in the Health Professions Educational Assistance Act.

HOUSE OPPOSES SENATE-PASSED CANCER BILL

HOUSE OPPOSITION to a Senate-passed cancer bill that would tend to fragment the National Institutes of Health has touched off a debate in Washington as to how best to organize a multimillion dollar campaign to conquer the disease. The American Cancer Society has sponsored a number of full-page ads across the country calling for popular support of the "put-a-man-on-the-moon" approach to the conquest of cancer, as contained in the Senate bill.

FLORIDA'S Congressman Paul Rogers, chairman of the House Interstate and Foreign Commerce Subcommittee on Health, and himself the author of a "cancer attack" bill that would beef-up cancer research but keep it within the framework of NIH, immediately branded the Cancer Society ads as "an attempt to bring the issue of finding a cure for cancer into a political setting."

IT IS REPORTED here that the Cancer Society ads are just the opening salvo in a "big money" grass roots campaign to pressure the Congress into passage of the Kennedy-Administration backed "Conquest of Cancer" bill. A month ago the AMA's testimony on this bill challenged the wisdom of separating cancer research from the mainstream of bio-medical research now carried on by the NIH.

COMMITTEE TO STUDY INFLATION IN HEALTH SERVICE INDUSTRY

PRESIDENT NIXON formally established a committee on the health services industry to furnish advice on ways to keep health costs from climbing too rapidly. In an executive order, the chief executive

said the committee—which is expected to consist of about 15 members—"shall provide advice concerning special considerations that tend to contribute to inflation in the health services industry."

MEMBERS of the advisory panel, due to be named shortly, shall be generally representative of medical professions and related occupations, hospitals, the insurance industry, other supporting industries, consumer interests and the public, according to the presidential order.

HEALTH CARE WAS singled out by the Administration for special consideration in the Phase Two Program of wage-price controls that will be administered by a cost of living council to which the health advisory group will report.

THE EXTENT to which the program will affect the medical profession and details of how it will work and what guidelines and/or controls may be promulgated have not been disclosed. However, a White House background paper spoke of "voluntary cooperation." ◄

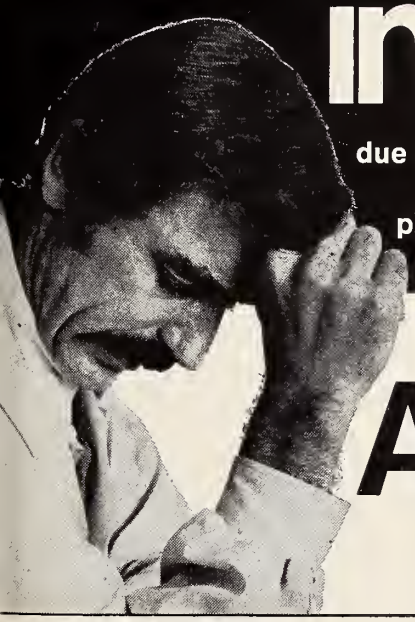
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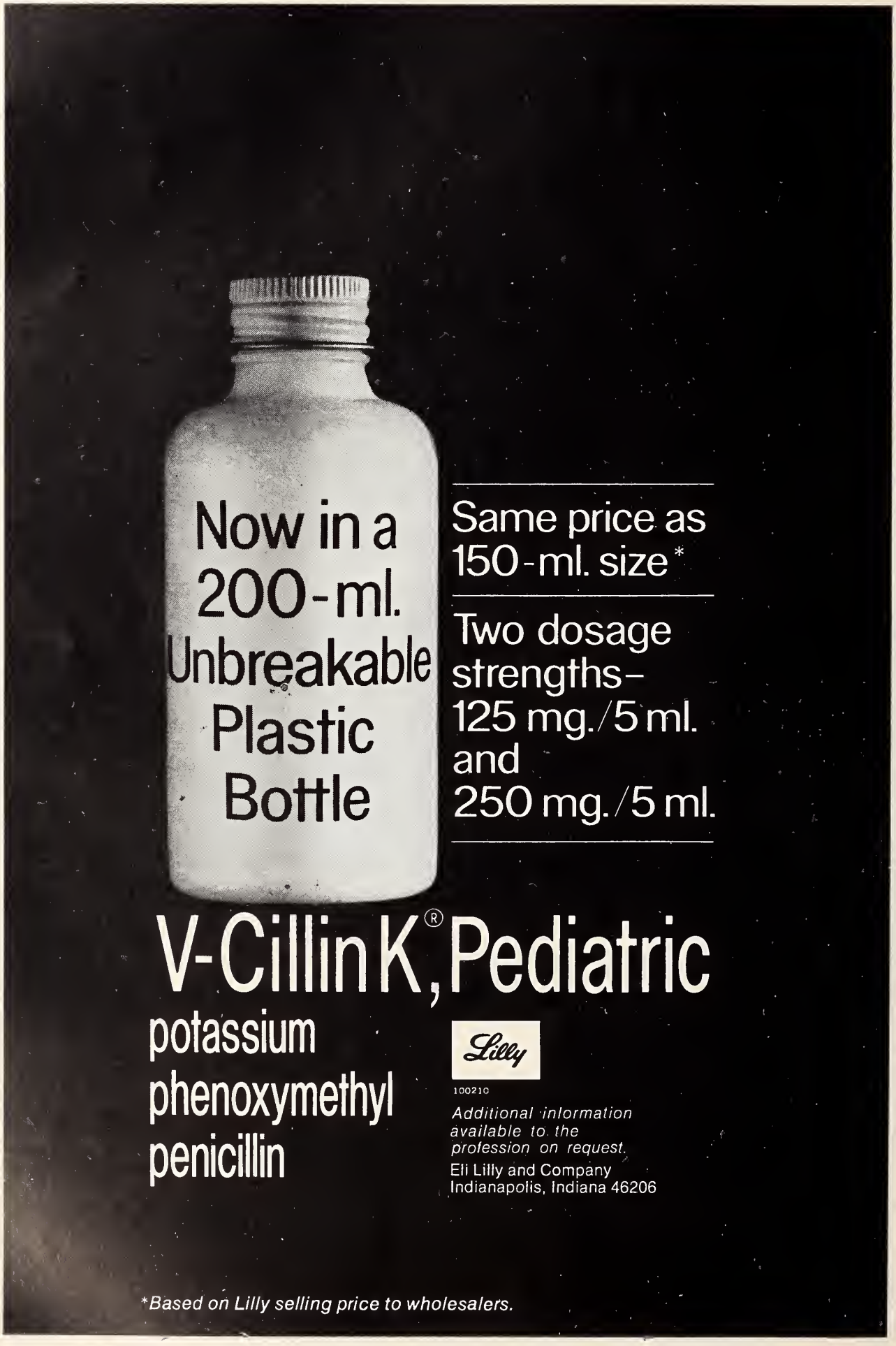
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References: 1. Monteseno, P., and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Titeff, A. S. Methyltestosterone thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Heliman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F. Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. Farris, E. J., and Colton, S. W. Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. Osol, A., and Farrar, G. E. United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. Wershub, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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Principles of Early Management in Massive Injuries of the Hand

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*Indianapolis**

WHILE hand injuries are among the most commonly encountered problems in a hospital emergency room, the majority of these injuries are minor in degree and heal with excellent function following brief medical attention. Less frequently, the injury may involve structures vital to function and result in significant disability unless a high degree of surgical skill is applied to their repair.

Finally, there are those rare injuries whose severity is such that it is obvious from the first that major functional loss will ensue. From a surgical point of view, such cases represent major therapeutic challenges that require the most careful judgment if the best possible result is to be obtained.

It is with such catastrophic injuries that this paper is concerned. Two cases that were recently treated on the Orthopaedic Service at the Indiana University Medical Center will be presented in an effort to emphasize the basic principles involved in their care. In presenting this material, the author intends to stress the necessity of a conservative surgical approach if maximum function is to be preserved.

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Case Reports

Case I: A 28-year-old male was injured in a laboratory accident when a porcelain container he was handling exploded. He was seen in a local hospital and then referred to the Medical Center. In addition to multiple lacerations of both eyes and ruptures of both eardrums, the patient suffered severe injuries of both hands. The right hand was traumatically disrupted in the interspace between the index and long fingers and their respective metacarpals to the extent that the wrist joint was exposed (Fig. 1). Multiple metacarpal fractures, dislocation of the thumb at the carpo metacarpal joint, and two phalangeal fractures were also present.

The wound was liberally coated with very small fragments of porcelain. The flexor tendons to the index finger, the digital nerves of the index and the digital nerve on the radial side of the long finger were all disrupted in the palm.

On the left (Figure 2), the little finger had suffered an almost complete traumatic amputation, and several soft tissue wounds were present in the hand, including a large soft tissue defect associated with the loss of the digital nerve on the radial side of the proximal phalanx of the index finger. The thumb was dislocated at the carpo metacarpal joint. The wounds were coated with porcelain fragments.

The patient was taken immediately to the operating room, where a general anesthetic was administered and the Ophthalmology Service performed a debridement of both eyes, the ENT Service examined and cleansed the ear canals, and the Orthopaedic Service attended to the hands.

Both hands were subjected to a careful cleansing with Phisohex and water and the wounds were flushed extensively with large quantities of normal saline. A careful effort was



FIGURE 1

THE right hand has been severely injured. The space between the second and third metacarpals has been disrupted so extensively that the proximal carpal row is exposed. The index and long finger metacarpals and the proximal phalanges of the ring and little finger are fractured and the thumb is dislocated. The wounds are coated with small fragments of porcelain and the flexor tendons and digital nerves of the index finger and the digital nerve on the radial side of the long finger are disrupted in the palm.



FIGURE 2

ON the left hand there is an almost complete traumatic amputation of the little finger and multiple severe soft tissue wounds including a 2 cm defect on the radial side of the proximal phalanx of the index finger. The thumb was dislocated at the carpo metacarpal joint. The disruption of the thumb web did not involve major vessels or digital nerves.

made to remove as many porcelain fragments as possible.

All fractures and dislocations were reduced and fixed with multiple small Kirschner wires. A few loose silk sutures were employed to close the proximal portion of the wound of the right palm while the remainder of the wound was left open (Figure 3A). No effort was made to perform tendon or nerve repair. On the left hand, the traumatic amputation of the little finger was completed and the wound was closed with a few loose silk sutures. Each fracture and dislocation was reduced and internally fixed with Kirschner wires while the soft tissue wounds were left open.

A massive dressing composed of large numbers of fluffed sponges was applied with mild pressure to each hand. Immobilization of the part was accomplished with plaster splints held in place with elastic bandages. Both hands and wrists were placed in the position of function.

Tetanus antitoxin and antibiotics were given. Five days after the initial surgery, the patient was returned to the operating room where the wounds were again cleansed and closed with split thickness skin grafts twelve thousandths of an inch in thickness. New pressure dressings were applied.

Some weeks after the grafts had



FIGURE 3A

THE volar aspect of the right hand is shown here immediately following surgical debridement and wound suture. The fractures and dislocations have been reduced and fixed with multiple Kirschner wires. The traumatic amputation of the tip of the index finger has been left open. The other wounds have been closed loosely except for a sizable skin defect in the interval between the index finger and long fingers. Five days after injury those wounds which had been left open were closed with split thickness grafts.

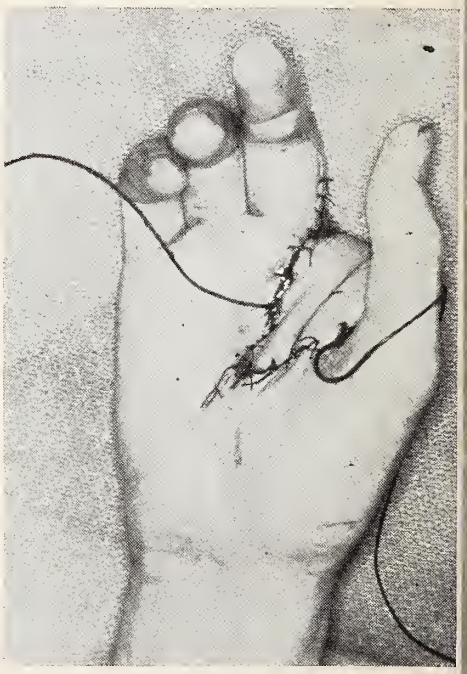


FIGURE 3B

EIGHT weeks after successful closure of the original wounds, the skeleton was filleted from the index finger, a deep scar was excised from the palm adjacent to the index finger and the resultant defect was covered with the skin of the index finger. The two digital nerves of the filleted index finger were used as free grafts to repair the defect in the digital nerve of the radial side of the long finger of the right hand and that of the digital nerve on the radial side of the index finger of the left hand. A palmar view of the right hand is shown immediately after the insertion of the index finger skin. Note the heavy black silk drains in place. They minimize complicating hematoma formation and will be removed at 24 hours. Sensation returned to the radial side of the long finger 10 months after the grafting procedure and excellent motion was present in all the digits. Sensation also returned to the radial side of the left index finger by 10 months following nerve grafting.

healed the reconstruction program was continued (Figure 3B). The right index finger was sacrified and its two digital nerves were used as free grafts to mend the defect in the digital nerve of the radial side of the right long finger and the defect in the digital nerve on the radial side of the left index finger. The skin of the index finger was converted into a pedicle flap that was inserted into the palm of the hand after the bulk of a large palmar scar was excised.

On the left the large soft tissue defect on the radial side of the index was closed with a split thickness skin graft. Four weeks after, the graft was excised and a local pedicle rotated in to fill the defect. Four weeks later a free nerve graft was inserted to bridge the gap in the underlying nerve (Figure 4).

At the present time the patient has regained very useful vision, has had successful repairs of both eardrums and has been able to return to his full professional activities.

Case II: A 21-year-old factory worker was referred directly to the Orthopaedic Service following severe injuries to the hands when both were caught in a punch press. X-rays were obtained, tetanus toxoid and antibiotics were given, and the patient was taken to the operating room, where a general anesthesia was administered and the wounds were cleansed with Phisohex and water and were then subjected to a prolonged lavage with normal saline.

The right hand had suffered traumatic amputations through the middle phalanges of the index and long fingers (Figure 5), while the left hand demonstrated traumatic amputations through the midportion of the proximal phalanx of the index finger and through the bases of the proximal phalanges of the long and ring fingers (Figure 6). The volar skin and the neurovascular bundles of the distal half of the little finger had been traumatically reflected but possessed intact proximal attachments.

Limited debridement of obviously devitalized tissue was performed and, in the case of the index and long fingers of the left hand, removal of the remnants of the middle phalanges allowed loose closure of the amputation stumps. On the right, the stumps of the index, long and ring fingers were resected to an amount sufficient to allow closure of the skin edges. A split thickness skin graft was applied to the little finger some seven days



FIGURE 4

THE left hand was initially treated by debridement and loose closure of the traumatic amputations of the little finger and the tip of the ring finger. The large tissue defect over the radial side of the index finger was closed with a split thickness skin graft that was applied five days after injury. Four weeks later a local pedicle flap was rotated into the defect. Four weeks after the insertion of the pedicle one of the nerve grafts from the right index finger was used to bridge the gap in the digital nerve. During the same operative procedure, a nerve graft was performed on the right long finger.

The end result some 10 months later is shown here. Sensation has returned to the radial side of the index finger which, along with the thumb and long finger, has regained full motion. There is a fixed flexion contracture of the partly amputated ring finger which is, nevertheless, a useful appendage.



FIGURE 5

THIS 21-year-old factory worker caught both hands in a punch press and received extensive digital injuries. The right hand, shown here, has suffered traumatic amputations through the middle phalanges of the index and long fingers.



FIGURE 6

THE index finger of the left hand has been amputated through the midportion of the proximal phalanx while the long and ring fingers of the left hand are amputated through the bases of their proximal phalanges. The volar skin and the neurovascular bundles of the distal half of the little finger have been reflected in a large skin flap which has questionable viability.

after injury when it became apparent that the volar skin flap had died.

All wounds eventually healed and the patient returned to work although the permanent disability that remained required adjustments in his job (Figure 7).

Discussion

Each case illustrates several aspects of the immediate surgical care of massive injuries of the hand. The essentials of treatment are four in number and include: limited debridement of wounds; fixation of fractures and dislocations; closure of wounds; and the application of a pressure dressing.

1. Limited Debridement of Wounds—Every experienced hand surgeon has seen injuries in which hand function has been irretrievably lost as the consequence of overly enthusiastic wound debridement. Faced with a massive hand injury, the surgeon must do his best to preserve all viable tissues. This is true even when it is evident that the preserved digits or tissues will not retain their normal function. The value of this policy is illustrated by Case I when the functionally useless index finger of the right hand was preserved to later serve as a source of nerve and skin grafts that were essential to the final reconstruction program.

   When the surgeon is confronted with multiple digital amputations, as in Case II, every effort should be exerted to preserve the stumps that are present. On the other hand, limited resection of the bone ends is justified if necessary to approximate the wound edges over the stump. In those instances where one cannot be certain that the skin flaps will survive, it is far better to take the optimistic approach and close the questionable skin loosely over the stump rather than run the risk of sacrificing useful stump length.
2. Reduction and Stabilization of Fractures and Dislocations—Reduction and stabilization of fractures is an essential step in the care of massive injuries of the hand. When skeletal integrity is lost, the surrounding soft tissues are prone to suffer further damage that may be adequate to tip the balance against survival of the part.

   In most open wounds of the hand internal fixation of associated fractures and dislocations is preferable to the more conventional methods of immobilization. The advantages of internal fixation are evident in Case I where the varied nature and location of the fractures and the obvious need for frequent wound dressings made it highly unlikely that simple plaster immobilization would suffice. The insertion of Kirschner wires, on the other hand, allowed good stabilization of the skeleton yet permitted ready access to the wounds without fear of losing reduction of the various fractures and dislocations. A word of caution is in order here. The use of internal fixation techniques requires some experience and skill if constant success is to be achieved.
3. Wound Closure—After debridement of the injured tissues and stabilization of the skeleton has been accomplished, the surgeon concerns himself with wound closure. In general, there are two courses of treatment open: the wounds may be closed immediately, or closure may be carried out after a lapse of several days.

   Immediate closure is to be preferred in the great majority of hand wounds. In Case II, immediate closure of the amputation stumps was gained by approximation of the wound edges and, in the case of the left little finger, by replacement of the skin flap. In other cases it may not be possible to approximate the skin edges and



FIGURE 7

THE end result of conservative surgical therapy is shown here. On the right hand the involved phalanges of the index and long fingers were resected enough to a degree sufficient to allow closure of the skin edges over the stumps.

Closure of the index, long and ring finger stumps of the left hand was accomplished by limited resection of the involved skeleton. The skin flap on the volar aspect of the little finger died and was replaced with a split thickness skin graft.

wound closure requires the application of split thickness skin grafts. In Case I, in contrast to Case II, the wounds were grossly contaminated with porcelain fragments and it was judged that immediate closure would be complicated by infection. Accordingly, the wounds were left open for five days and were then closed with a combination of wound edge approximation and the application of split thickness skin grafts.

4. Application of a Pressure Dressing—After appropriate attention has been directed to wound closure, the hand is immobilized in the "position of function" with a bulky dressing that applies mild and even pressure to the entire hand and wrist. The dressing consists of a large number of fluffed sponges held in place with an elastic bandage. The dressing is supplemented with a plaster splint that is arranged to hold the wrist in 50% dorsiflexion and the metacarpal and interphalangeal joints in 50% of palmar flexion.

The pressure exerted by this dressing controls postoperative hemorrhage and minimizes edema formation. Wound healing is enhanced. Maintenance of the dorsiflexed position at the wrist and the flexed position in the fingers prevents capsular and ligament shortening and thus avoids the limitation of motion that would result from inappropriate joint position. In Case I a pressure dressing was applied to both right and left hands on three different occasions. In Case II only one dressing was necessary on the left while dressings were applied on two occasions on the right.

Summary

Massive injury of the hand is rarely seen. When it does occur the surgeon must make every effort to preserve all viable tissues through a careful initial treatment program.

Initial treatment is based upon limited wound debridement, reduction and fixation of fractures and dislocations, appropriate wound closure and immobilization of the wrist and hand in a pressure dressing with the joints in a functional position. ◄

FDA Approves Bone Cements

The Food and Drug Administration announces approval of New Drug Applications for Methyl, Methacrylate* for cementing in place total hip replacement prostheses.

This approval makes available a significant new therapy for disabled patients. A significant number of such patients can now be at least partially rehabilitated through judicious use of this new material in orthopedic surgery.

The drug will be available for restricted use as specified in the package insert. (The manufacturer will mail each orthopedic surgeon a copy of this insert.)

The Food and Drug Administration wishes to express its appreciation to the American Academy of Orthopaedic Surgeons for help and cooperation during the approval process. Special appreciation also is due the orthopedic surgeons who served on the FDA's Ad Hoc Advisory Committee. Further, the FDA wishes to compliment the Academy on its current program to develop training courses in 23 centers to assist orthopedic surgeons in the proper use of this new drug.—*FDA Drug Bulletin,* Oct. 1971.

* Surgical Simplex P Bone Cement and Surgical Simplex P Radiopaque Bone Cement, Howmedica

The LaMaze Method of Preparation for Childbirth

MONA K. STERN, M.D.
Gary

Synopsis

THE Lamaze method of childbirth training consists of classes in relaxation, proper breathing in labor and more efficient techniques for delivery. The purpose of such training is pain relief for the woman in labor, so that she will need less sedation and anesthesia. This is of unquestioned benefit to the child. Such trained women also are more able to cooperate with the physician in the delivery.

The Lamaze training program is the subject of this article in the hope that more physicians dealing in obstetrics will become familiar with these techniques.

Originated in France

More and more women are seeking training in preparation for childbirth. They seek this because they expect their first child and are apprehensive about what will happen, or because they have had an unhappy experience with their first labor and delivery and wish to know how to help themselves the next time. The most common method of training for childbirth is the Lamaze method, sometimes called psychoprophylaxis. This method originated in France and spread to this country during the last 15 years.

It would be advantageous for physicians dealing in obstetrics to be familiar with this type of training so that they can aid their patients in their wish to cooperate in the birth. The purpose of the Lamaze training is pain relief in labor and it is valuable, in that trained women need less medication during labor and often deliver with just local anesthesia. They are taught how to relax and breathe properly so as to lessen the intensity of the uterine sensations. The pain will not be eliminated, of course, but it becomes tolerable. If more women were trained in the Lamaze method, perhaps we could lower the newborn mortality rate, which is too high for a country with our advanced technology.

Classes Taken by Both Parents

The Lamaze training classes are taken by the couple as a unit. The husband must be involved, as his role is extremely important. He coaches his wife in her labor, knows what she must do, and what he can do to help her. The classes take six weeks and begin about eight weeks before the due date.

In the first class the couple is taught basic anatomy, what the pelvic organs look like, how the cervix changes during labor, and what pathway the baby takes as it is born. Also in this class the breathing for early labor is taught—namely, effacement breathing. It consists of slow, deep chest breathing, done during the entire contraction, and accompanied by the hands rubbing the abdomen in a circular motion. This breathing pattern is begun when the pains begin to interfere with the woman's normal activities.

In the second class simple calisthenics are taught, not to be used in labor, but just to help eliminate some of the aches and pains of the last trimester. These three are done daily: (a) sit cross-legged with soles of feet together and press knees down to floor 10 times; (b) lie on back, breathe in and slowly raise right leg up, breathe out and lower leg to floor, five times on each side; (c) lie on floor with knees bent, feet on floor, and slowly flatten back onto floor, to be done five times.

Relaxation Taught

In this session the woman also learns the most important exercise of all—the one which will teach her how to relax. It is useless to walk in on a woman in labor and tell her to relax. However, if she has practiced daily for several weeks beforehand, she can relax in labor. The more relaxed she is, the less pain she feels. In fact, one of the duties of the husband, when his wife is in early labor, is to remind her to do one contraction incorrectly. She should hold her breath, grip the chair, brace herself against the pain. She will not try it again as she will discover that the contractions hurt twice as much when she is tense and holding her breath, as compared to when she is relaxed and breathing properly.

To stay relaxed during a contraction takes intense concentration, and this focus for the brain is probably what lessens the intensity of the pain focus. In a way, it is a rehearsed, built-in, automatic distraction. The relaxing exercise must be done daily and takes two to three weeks to learn. The woman lies on the floor with pillows under her head and her knees. To begin, she makes a fist, stiffens her arm and raises it off the floor. Her husband stands over her and

holds her other hand, gently swinging her arm while she lets it hang limply in his grip. If done correctly the relaxed arm will stay loose whether the other arm is tightened or not.

To learn to relax the legs, the woman flexes her foot and stiffens the leg as it rests on the floor. Standing over her with his hand under her other knee, the husband gently raises and lowers it so as to feel whether the leg is relaxed. Again, when done correctly, the limp leg should stay so, even when the other leg is stiffened. When practicing, the woman tries various combinations; one limb stiffened at a time, then both arms, then both legs, then opposite arm and leg, then sequences of tensing and relaxing the arms and legs. The purpose of these exercises is to teach what it feels like when the limbs are relaxed. Eventually there is a definite sensation in the relaxed arm or leg, and after three weeks of practice, most women are able to recognize whether they are relaxed or not. In labor, of course, when a contraction begins she must relax totally. The more relaxed she is all over. the less pain she feels.

Breathing For Dilation Taught

Breathing for dilation is also taught in the second session. This breathing pattern is to be begun when the contractions are coming at five-minute intervals. This is a shallow, more rapid chest breathing or panting. It is learned at a fairly slow rate but is usually done more rapidly in actual labor. When first learning to pant, she may hyperventilate and notice numbness or dizziness. This rarely occurs in actual labor, but if it should occur, the woman knows she has only to slow her rate of panting to correct the situation.

In the third class session the couple learns the signs of transition, the third phase of the first stage of labor. They are taught what these possible signs are and that not all may occur. The signs of transition are; a) less than a minute between the end of one contraction and the beginning of the next — b) dilatation of between seven and ten centimeters — c) contractions of ninety seconds duration — d) perspiration — e) nausea — f) shakes — g) drowsiness — h) irritability — i) double peaks to the contractions. It is especially important for the husband to recognize the onset of transition. He can remind his wife that this is the shortest part of labor, use a cold wet washcloth to keep her awake, and, since trained patients are quiet patients, he must make sure that the nurses realize that she has reached this point.

The breathing pattern for transition is panting and blowing. The woman begins with a six-pant-blow pattern, the blow being a soft, sharp puff, as though to blow out a match. If a six-pant-blow pattern is not effective, she may try a five, four, etc., pant-blow. One pant-one blow is her last resort and she is to save that for the end of transition. She is also taught that whenever told not to push, at a time when she has the urge to do so, she should interrupt her breathing pattern and blow out forcefully over and over again. This is called "blowing the ceiling away" and is a way of resisting the urge to bear down.

In the third session delivery is discussed. It is emphasized that pushing is not done until permission is given or the urge is irresistible. The woman may feel the urge to bear down gradually, suddenly, or not at all. When she has permission to push, she takes a deep breath in and out, then another in and out, waiting for the uterus to gain impetus. Then she takes in the third breath, holds it, bends her chin down, grabs her bent knees with elbows out and bears down. (Of course in practice she merely assumes the correct position, holds her breath, and pretends to push. She does not really bear down when practicing.) After the first push, she blows out her residual air. raises her chin, gulps more air with her mouth open, holds her breath and begins the second push. This procedure is repeated again for the third push. Then she lies back and rests, breathing deeply. There is time for three pushes before the contraction ends. Bearing down is more effective if the back is kept rounded, rather than arched, and keeping the chin down and elbows out helps achieve this posture. If the husband or nurse can put an arm around her and lift her shoulders a couple inches off the bed, it will help her to keep her back rounded. It is emphasized that when actually in delivery, she must push as hard and as long as she can. This is because the harder she pushes, the less her pain. Many women have no pain at all at this point, and those who do say that even with the pain they felt a great relief in bearing down. The more effective she is in her efforts, the shorter the second stage of labor will be. Labor room pushing and delivery room pushing are similar except that in the former she grabs behind her knees and in the latter, she grabs the handles on the delivery table. The woman is reminded that the doctor may suddenly tell her to stop pushing when the birth is imminent and in that case she must quickly lie back and blow out forcefully over and over so as to cooperate in the delivery. Afterwards she will bear down for the delivery of the placenta.

Problems Discussed

In the fourth class the couples have the opportunity to read post partum reports of former students and discuss problems that had occurred in these cases. Possible difficulties are covered such as;

Question: What do you do if you cannot keep from pushing and the doctor is not there yet?

Answer: Ask the nurse to deliver the baby and then cooperate with her in the birth as you would have with the doctor.

Question: One woman stayed home

breathing and relaxing, waiting for the pains to become severe. What did she do wrong?

Answer: She barely made it to the hospital. Everyone feels the sensations of labor differently. You must watch the length of contractions and the interval between them. If the contractions last a full 60 seconds and come every five or six minutes, you go to the hospital regardless of what they feel like.

The fifth and sixth sessions consist of a tour of a delivery room, a talk by a couple who bring their baby and tell of a recent delivery, and further review and elaboration. Any specific worries are discussed. It is stressed that there is no success or failure involved in what the couples have learned. If they have practiced faithfully and the method does not help them throughout the labor, then it is the fault of the method, not of the couple.

Those husbands who have received permission to accompany their wives into the delivery room are coached as to where they will sit and what they can and cannot do. Postpartum reports are handed out to be filled out within two days of delivery. Other issues are discussed, such as breast feeding, care of the newborn, possible post partum feelings of depression, birth control methods available and the importance of the six-week checkup.

The couple is encouraged to discuss what they have learned with their physician so as to find out his attitudes toward these matters. For instance, the matter of sedation and anesthesia should be covered. This method does not work if the woman is heavily sedated. So, for trained couples, sedation such as demerol is recommended at about four or five centimeters dilatation in long labors. In transition after seven centimeters, and in very short labors, it often confuses the woman and increases pain. Since it is usually optional, the choice is up to the couple. Of course the woman may ask for help any time she feels she needs it. In delivery, most trained women need only a local anesthetic for the episiotomy repair as, if they are bearing down well, they significantly reduce pain. The baby emerging is a relief and to give a general anesthetic just for the moment of birth is not necessary for trained women. There is no stretching sensation at the vaginal outlet, just the backache and pressure on the rectum that have occurred during all the previous contractions. But all this must be discussed ahead of time with the doctor. The couple is told to inquire if pain medication during labor will be optional and, if all is going well, if a local rather than a general anesthetic will be possible.

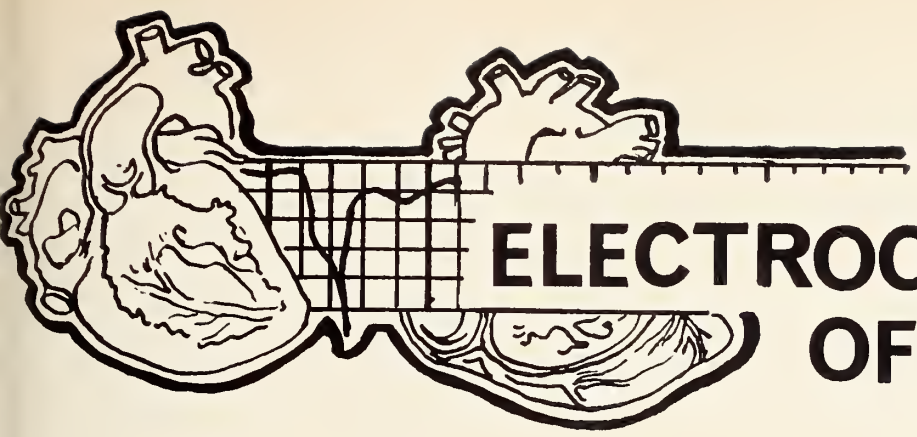
It is hoped that this summary of Lamaze training for childbirth will be of aid to physicians in dealing with expectant couples who wish by means of this training to fully participate and cooperate in the birth of their child. ◄

7535 E. Harold Avenue
Gary, Ind. 46403.

From *The Journal* 50 Years Ago

It is rather surprising how little attention has been given to syphilis in the study of diseases of the stomach. Only within the last three or four years has serious attention been given to this problem, authorities having previously passed the subject by with the brief statement that syphilis of the stomach was rare. The prevalence of lues and its widespread activities throughout the body make it manifestly an impossibility that the stomach should escape damage. Furthermore, it is an erroneous idea to conceive syphilis of the stomach only as a gummatous lesion, for it is a well known fact that the spirocheta pallida is a connective tissue parasite, and since the walls of the stomach contain much connective tissue, interstitial inflammation is possible.

Syphilis of the stomach, as one writer remarks, forms a fascinating problem, there being no clear cut symptomatology and no certain clinical findings to differentiate luetic gastric lesions from any other. The diagnosis can only be made by exclusion, and therefore no examination of gastric disease is complete that does not consider syphilis and include a Wasserman test. By so doing, within the last three or four years, more cases of syphilis of the stomach have been reported than had been previously in the history of medicine. . . . B. W. Rhamy, M.D., Fort Wayne, "Ulcer of the Stomach and Duodenum: The Role of Syphilis in Peptic Ulcer." *JISMA*, December 1921.



ELECTROCARDIOGRAM OF THE MONTH

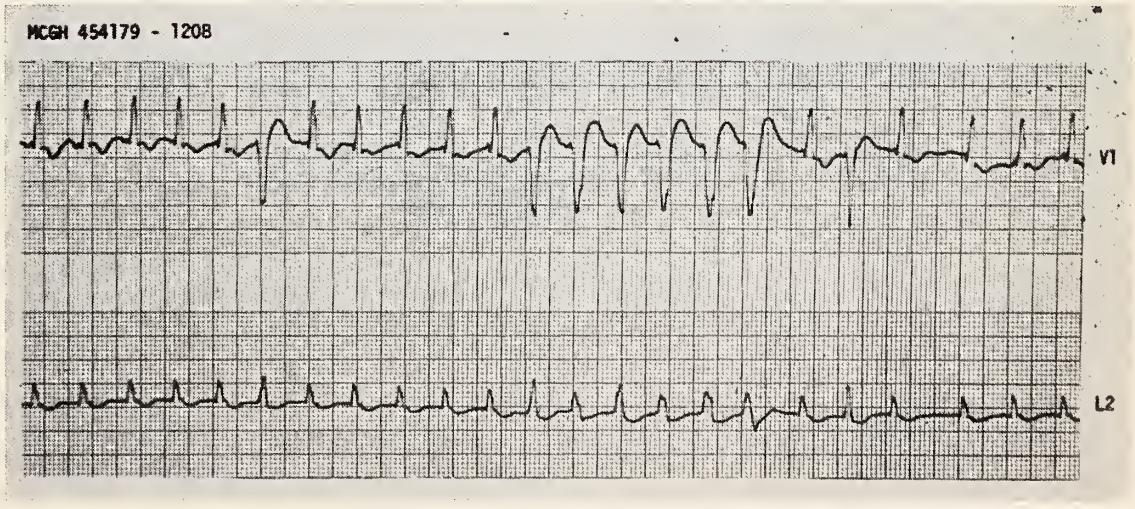
The ECG as a Three Dimensional Phenomenon

CHARLES FISCH, M.D.
*Indianapolis**

THE electrocardiogram (ECG) is a three dimensional phenomenon. This is the case because the current responsible for the ECG generates in the heart which is immersed in a volume conductor with a three dimensional conduction of the current. As a result, recording in only one plane, e.g., frontal (leads I, II, III, AVR, AVL, AVF) or horizontal (V_1-V_6) may be misleading. Errors in interpretation of both duration and appearance of the ECG waves may result. This is particularly true if one attempts to study ventricular aberrancy such as may be seen with ventricular premature complexes (VPC).

The accompanying figure is an example of utility of studying the ECG in more than one plane. Leads V_1 and L_2 were recorded simultaneously. The basic rhythm is one of atrial fibrillation with a ventricular rate of about 150. Some degree of aberrancy is noted and, although the sixth, twelfth and nineteenth complexes (which are slightly aberrant and accurately coupled to the preceding QRS) suggest VPC, the diagnosis is somewhat difficult because of the minimal aberrancy and a lack of the compensatory pause. The problem is solved by inspecting V_1 which clearly identifies bizarreness of the VPC. The mean QRS vector of the VPC parallels L_2 in the frontal plane but its posterior orientation (the supraventricular QRS have an anterior orientation — positive in V_1) does not become evident until a horizontal lead, such as V_1, is suspected. ◄

* From the Krannert Institute of Cardiology, Marion County General Hospital, and the Department of Medicine, Indiana University School of Medicine, Indianapolis 46202.



ATRIAL fibrillation with ventricular premature complexes recorded simultaneously in leads V_1 and L_2.

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ECG Lab to Be Named For Dr. Arthur Richter

Dr. Arthur B. Richter is being honored for his 26 years as head of the Department of Electrocardiography at St. Vincent Hospital in Indianapolis by the designation of the ECG Laboratory in the new St. Vincent Hospital as the Arthur B. Richter Electrocardiography Laboratory.

Dr. Richter was appointed to head the Department when it was first organized in 1945. St. Vincent was the first private hospital in Indianapolis to create a separate facility for cardiography. Under his direction the laboratory has grown and prospered—with a steady improvement in equipment, accommodations, staff and accomplishment.

Dr. Richter retired as head of the ECG Department this summer and continues his private practice in internal medicine. He is succeeded by Dr. Edward F. Steinmetz, who administers the department now and will establish it in the new St. Vincent Hospital now under construction.

Indiana and Indianapolis can take pride in the development of electrocardiography. One of the first, if not the first, instruments was brought to Indianapolis by Dr. George S. Bond in 1914. This was one of the first models, so sensitive to outside electrical interference, that it required a room sheathed in copper screening for proper function.

Improvements in electronic circuitry steadily improved the instrument and in the 1940s the direct writing machine was perfected. St. Vincent was the first hospital in Indiana, in 1942, to use V-chest leads. It is thought that the first course in electrocardiography in Indianapolis for house staff and attending staff was conducted at St. Vincent when vectorcardiography was taught by Dr. Richter and Dr. Dan Urschel.

The use of electrocardiography has increased tremendously over the years. The St. Vincent department has tallied an annual increment of almost one thousand tracings for the past few years. It is fitting that the accomplishments of this diagnostic device, one of the most useful of all, should be continued in a setting dedicated to one of its pioneers, Arthur B. Richter.

Guest Editorials

Perils in Pursuing Perfection

SOME physicians think that they are in the business of trying to make people normal, and to make organs function perfectly. We take it for granted that it is desirable to be free of symptoms, to achieve perfection in organic function, and to squeeze into the vague but desirable mould of "the normal."

There is no way of achieving the ideal. But we try. We aim at ideal weights, and ideal blood counts, and ideal x-ray findings. We assume it would be cause for congratulations if we could get the harassed, worried, hypertensive executive to take it easy. But we forget that if he succeeded in taking it easy, his business might collapse. It needs a compulsive, self-driving, potentially hypertensive boss to keep it going in high gear. If the doctor succeeded in relaxing the executive to the point of hypotension, profits would fall, stockholders would swear, and laid-off employees would then develop high blood pressure.

Peptic ulcer is said to be related to repressed hostility acting on a hyperacid, hypermotile stomach. If we achieve perfect digestion, the victim will either exhibit his hostility (instead of repressing it), or give up the fight entirely and stop being hostile. If he does that, he may lose the passion which kept him going. If he exhibited the hostility instead of repressing it, he would exchange an unpleasant but benign ulcer for a dangerous, possibly fatal coronary.

Let's face it, neither the human

body nor the human mind, nor — for that matter, the human soul — is perfectible. Crises keep us toned up. Without them, we would lose muscle tone and emotional drive. But with crises we have other problems. People are entitled to emotional storms — even to occasional "breakdowns" of such severity as to require hospitalization. The neatly patterned carpet or blanket has a chaotic pattern on the underside. It is possible to have a body with no tension and a mind with no worry — a dead body, of course. The most important tasks of our time cannot be performed by men who are free of anxiety. Anxiety is the motor that drives us. A machine can function free of anxiety — but not a human being. And you can't take pleasure in being human, if you have to brood about your score. If you can't enjoy your own abilities, because of a hopeless pursuit of perfection, you will lose on both scores. You won't make enjoyable use of your limited potential — and you won't achieve perfection either.

The human being has all kinds of foibles — physical, spiritual, and emotional. But since he is stuck with those limitations, he should learn to enjoy them. Perhaps this is our mission: to show how our patients can live with their modest human skills rather than to send them off on the wild goose chase after the mythical norm.—**Reprinted with permission from The Journal of the Medical Society of New Jersey.**

Equality of Sacrifice: A Good Idea, by George!

GEORGE Meany has complained that there is no "equality of sacrifice" in President Nixon's New Economic Policy. He's certainly right about that. So far, business has received less and been asked to give up more than any other element of American society.

The Secretary of the Treasury, John B. Connally, clarified this issue before the House Ways and Means Committee. He said.

To be complete, the record must include the impact of the Tax Reform Act, plus the Administration's change in depreciation regulations and the tax proposals of the New Economic Policy. If the impact of these measures is spread over the five years, 1969 through 1973, the result is startling:

Federal income tax payments of individuals will have been reduced by almost $34 billion. Tax payments on corporate profits will have declined by slightly more than $1 billion.

Further, as Mr. Meany well knows, the owners of American industry are taxed twice—once under the 48% corporate profits tax, and again when dividends are taxed as income.

Put it all together and it hardly sounds like favoritism for business.

Mr. Meany should know, too, that until the 1971 upturn profits as a percentage of the Gross National Product were the lowest since the Depression '30s.

Thus it is obvious that individuals are in fact not receiving worse treatment than business under the President's program.

Putting still more money in the hands of the consumer would be worth considering if there were some evidence that consumers would spend enough of it to give business the needed stimulation. But the evidence is on the other side. Consumers are currently saving at near-record rates —above 8%.

Consumers are saving because they are scared. With unemployment high and business sluggish, we all feel economically insecure, so we save.

Increased business activity should provide jobs for the unemployed. When unemployment drops, consumer confidence will return and consumers will spend again, further stimulating business.

The key to recovery, therefore, is business.—**Arch N. Booth, Executive Vice President, Chamber of Commerce of the United States.**

Response for the Fifty Year Club by Dr. Arthur W. Records

BEING a member of the "Fifty Year Club" and as spokesman for the 24 members, I want to thank you for the certificate of distinction; also for the gold pin recognizing us for our 50 years of service in the practice of medicine.

Too, I want to thank Dr. Scamahorn for appointing me to be the response speaker for this year's club.

During the past 50 years I feel that the doctors and scientists have made wonderful advancement in the field of medicine to the advantage of all the American citizens.

The members of this class have seen the passing of many events as well as the beginning of others, such as the passing of the "horse and buggy days" which were replaced by the "horseless carriage"; the passing of the two-room doctor's office for the formation of the modern clinics; office prescribing has been replaced by prescription writing; office fees of one to two dollars have increased to $10 to $20 for an office visit; home deliveries have been replaced by hospital obstetrics, with an increase in cost from $15 to $25 in the home to the present-day doctor and hospital costs amounting to $500 to $600.

Many of my obstetrical patients never called me until the night of the delivery. Since the women wore "mother hubbards," neighbors did not even suspect pregnancy. Not so today! With "hot pants" *nothing* is hidden.

Our office hours were for 24 hours a day seven days a week, including holidays. Today one does not dare get sick if the doctor is not in his office.

Today with all the increased cost of hospitals, with x-ray, more complete laboratories and well-trained personnel, the public is receiving excellent medical service. With preventive medicine, with vaccination, immuni-

zation, skin tests, etc., plus new drugs and especially antibiotics, we are enjoying better health and rapid recovery from our ills.

So far as the future is concerned, I predict that in this space age more attention will be given to "trace elements" and now, with the atomic absorption spectophotometry, we will be able to take a blood sample and determine the amounts and kind of trace elements present. We will now begin treating the molecules in place of the cells. This will be the beginning of a new field of therapy which could supply the missing element, thereby increasing our life expectancy a hundred years or more.

Now, as with government controls in many other fields of endeavor, no doubt they will affect the practice of medicine even more in the days to come.

Finally, I predict even more rigid controls will be enacted with regard to pollution, drug abuse, the labeling of poisonous drugs and overdosing with medications.

In conclusion, may I again thank you all for this distinguished honor given to the "Fifty Year Club." May you all live to receive a similar award. Now, as Red Skelton would say, "May God Bless."

Editorial Notes . . .

The nation's first three Radiologist's Assistants were graduated recently from Duke University. The graduates will be followed for three years to gauge their effectiveness and performance, after which a final evaluation will be made. The graduates were trained as primary-care Physician's Assistants prior to radiology training. The total training time was two years.

FDA proposes a regulation to require "child-proof" closures on narcotic, depressant and stimulant drugs used in the home. The proposed standards for closures require that 85% of a test group of 200 children between 42 and 51 months be unable to open the special packaging and only 80% after a demonstration. Ninety percent of a test group of 100 adults would have to be able to open the package.

The American Association of Blood Banks is conducting a public education campaign to encourage and expand the donation of blood. Voluntary donors are favored as a source of blood for transfusion because purchased blood has been found to be more likely to transmit hepatitis. Another reason in favor of the free donation of blood is to prevent other tissues, such as corneas and kidneys, from assuming price tags.

Eight hundred Framingham families selected at random from the 1644 families in which both husband and wife participated in the original Heart Study will be the subject of an Offspring Study. Children of the test families will be at approximately the same age as their parents who volunteered for the original study 22 years ago. It is hoped to determine to what extent factors known to increase susceptibility to atherosclerosis tend to cluster in families, and to assess the importance of hereditary factors.

A proficiency testing program will be offered to physicians who wish to evaluate their own office laboratories. The American Society of Internal Medicine and the College of American Pathologists have designed a Proficiency Evaluation Program for monitoring the capabilities of the office lab and for conducting an economical, comprehensive evaluation of the test results.

The newly opened addition to the Riley Hospital includes a Parent Care Pavilion designed so that mothers may stay in the hospital and assist in the care of their children. The $53 daily charge, covering meals and accommodations for both mother and child, compares with an $86 daily charge for room, board, and nursing care in one of Riley's private rooms. One nurse and a ward secretary will be responsible for the entire 24-bed unit during the day. This compares with seven nurses required for a traditionally organized unit. At night, nurses make rounds through the unit and resident physicians are on call.

The VA recently announced that it has 32 drug rehabilitation centers in operation, 27 of which have been activated since June. Drug dependence is now classified as an emergency for purposes of hospital admission. The VA program to help veteran drug abusers includes a follow-up program, specialized training courses for physicians and allied health workers, and a policy of assisting veterans with "other than honorable" discharges acquired because of drug abuse to apply for re-characterization of their discharges.

Substances sometimes used in laundering clothing, diapers and bedding for hospital nurseries may cause poisoning in newborns because of skin absorption. The bacteriostatic agent 3-4-4' trichlorocarbanilide (TCC) is still used in some laundries and may cause methemoglobinemia. The sodium salt of pentachlorophenol (PCP), used in an antimicrobial neutralizer product, is also dangerous and can cause illness and death. The American Academy of Pediatrics advises that physicians should monitor laundry practices. Some of the newer laundry agents, such as enzyme-detergent combinations and optical brighteners, have not been determined to be safe or dangerous and should be avoided.

The Breathalyzer and the Intoximeter are two instruments for determination of blood alcohol concentration which have established a good reputation for reliability. The State Toxicology Laboratory of North Dakota Uni-

versity and the Insurance Institute for Highway Safety are quoted by the Indiana Traffic Safety Council to the effect that there are several inexpensive, disposable devices on the market which purport to test accurately for alcohol levels. "This study indicates poor results from most of these disposable screening devices."

Pregnant women should use seat belts. Both mother and fetus are safer despite the impression that the restraint may injure the fetus. Most cases of fetal death occur because the mother is killed. The Indiana Traffic Safety Council cites a University of Oklahoma School of Medicine study to support the seat belt safety rule and urges constant use of the lap strap for long life.

Pharmaceutical research in relation to pain-killing drugs has been directed mostly to the discovery of replacements for morphine. Widespread narcotic addiction now makes it advisable to search out an antagonist for heroin. More than 25 of the largest drug companies and the Pharmaceutical Manufacturers Association have announced a combined, coordinated and massive effort toward this objective. An agent similar to methadone but more effective is the goal.

One-third of the nation's traffic deaths in 1969 involved persons 15 to 25 years of age. This age bracket constitutes 21% of all drivers but members of this group were involved in 34% of 1969's fatal accidents. In absolute figures this amounts to 17,000 fatalities in one year—7400 more than would have been the case if the below 25 drivers had the same death rate as those over 25.

The Eastern Women's Center in New York City performs abortions—over 4000 since it was opened five months ago. Random sampling of 100 cases shows that 79% were from outside New York state and only seven percent were from New York City. Sixty-eight percent of the patients were not married, 15% were married, 12% were separated and five percent divorced. Three-fourths reported that they had not used any method of birth control. Some 80% of the patients, however, had IUDs inserted or received prescriptions for birth control pills before leaving the center.

The Indiana Traffic Safety Council reports that a special study indicates that safety belt usage varies from 16% in large metropolitan areas to nine percent in small cities. The study also showed that persons most likely to wear belts are those who have attained "higher education," have had a friend injured, who rate belts as comfortable and convenient, and also who do not smoke while driving.

The deadline for air bags or other passive restraint devices in cars has been advanced two years to August 15, 1975. The date was chosen to correspond with introduction of the 1976 models. The standard for passive restraints will be protection of all seating positions in a 30 mph head-on crash, in angular and lateral crashes at 20 mph, and in roll-over crashes.

The FDA has tightened its regulation against toys which may cause injury. Toys having any components with a potential for lacerating or abrading were already banned, when experience showed that appendages such as eyes, tongues, ears, etc. have caused injury by aspiration and ingestion. The new proposed regulation bans any such toys unless such components are firmly attached or may not easily be exposed by disruption of the toy.

The FDA which, until recently, has insisted that methadone, when used in treatment of heroin addiction, be handled as an investigational drug, has indicated that it may approve it as a "new drug." Methadone has been used in the maintenance treatment of addiction since 1963, subject to FDA investigational drug regulations. The new status will not alter strict controls on distribution. The Bureau of Narcotics and Dangerous Drugs and Dr. Jerome Jaffe, director of the President's drug abuse operation, both favor tight control but urge its use in maintenance programs until something better comes along.

Hemodialysis at home is being utilized on an increasing scale by the VA. After a cautious start, it has been determined that, with adequate training of family, home use of dialysis equipment is very satisfactory. Hospital dialysis is available at 40 of the 165 VA hospitals, and 10 units for home use have been provided. Training for home use will begin soon at 15 more VA centers.

Aetna Cardio-Alert is a two-way radio network in Hartford, Conn., which transmits the ECG and other clinical information from the heart attack victim's location to the hospital emergency room. Advice about treatment of the patient prior to and during transportation to the hospital is relayed by cardiologists to the emergency ambulance attendants. The network has been financed by the Aetna Life and Casualty Company in an attempt to lower early mortality.

A hospital chaplain at the Fort Lyon, Colorado, VA hospital has found that former alcoholics, at least some of them, with proper training make excellent alcoholism and drug abuse counselors. Of the 26 graduates of three special courses, two are employed at this hospital and 18 are working for state, local and other government agencies, all as alcoholism counselors. ◄

Medicare

FREDERICK W. TAYLOR, M.D.

Indianapolis

AMERICANS are great social idealists and are forever endeavoring to aid natural evolution. Some attempts have been successful, others have failed. We are now in the process of witnessing such a failure in Medicare. Without question, its aims and intent are unchallenged. However, its operation and course indicate an early and expensive debacle.

Let there be no misunderstanding, Medicare or some government health subsidy is here to stay, but its glamour is dimmed by faults and unsuspected deficiencies. These loopholes will continue to grow and become more painful. A health plan which was originally to cost about three billion dollars, now in a brief four years has reached many times this. More discouraging is the fact there are no signs it will even hesitate at this point.

What are the causes of these miscalculations? Why are things not going as expected? Of course the problem is very complex with escalating medical costs closely tied with inflation. High among the many discouraging features of Medicare progress is the human element which originally was not completely assessed. It is the purpose of this discussion to point out some of these overlooked features in the hope that a more intelligent approach might bring some order out of chaos. Although there is much overlapping, these particular human frailties may be directed into three categories: the patient, the hospital, and doctor.

The 65-and-over patient has suddenly become the center of much care, thought and attention. No longer is the oldster sloughed off as of secondary concern. He likes this and quickly accepts all as his just due. He demands and gets the best. That is, of course, fitting and proper but some of the trimmings are by no means necessary and at times not desirable. He and his family want all the scientific studies that the law allows. These are myriad, with the medical profession keeping well ahead in presenting new angles of exploration. Some laboratory work is necessary, some desirable and some completely unnecessary. Who calls it quits? Certainly not the patient or his family, who want all angles explored. Most laboratory and x-ray studies can be done on an outpatient basis, but why do this when hospital admission is easier for all? It sounds more professional and Medicare paper work is greatly simplified. A free trip which isn't to be missed, and the patient wants to make the most of it.

A patient in his early sixties facing a non-emergent situation most likely will delay his hospital visit until his 65th birthday. Why not—for it is then free.

If Aunt Alice in her late seventies isn't doing so well and her doctor can't say if the cause might be arthritis, chronic heart or kidney disease or just plain old age—put her in the hospital for study. It's free if she has supplemental health insurance and costs only a few pennies on the dollar if she hasn't. The doctor likes it that way and so does the family, for Aunt Alice is getting the best, even though the best will not cure her. The endless gamut of laboratory tests is justification for continued hospitalization and study.

When Medicare first came into being there were groans from hospital administrators. The allocations from the government were below actual per diem costs and lower than those from Blue Cross. This was true but the entire plan has been a Godsend to those institutions with a heavy charity load of oldsters. Medicare took up the slack and paid for many of these patients who were cared for by charity before. After all, the hospital voluntarily participates in Medicare. They are not forced to join, so there must be an overall advantage. While Medicare covers about three fourths of the costs, most patients have supplemental coverage so that the hospital ends up subsidizing less than three percent of the Medicare patient's bill.

Many administrators seem to have taken the attitude of just watching hospital costs reach their own level. When it can be shown actual costs are greater than receipts, there will be an increase in both Blue Cross and Medicare allowances. Added costs are passed on to one of these agencies or the patient himself. To the hospital, the economic importance of the true charity patient becomes secondary. These statements won't receive universal acceptance but nevertheless contain much truth.

The x-ray department and laboratories are money makers. Their use is urged for all and their cost, but not their profit, is passed on to the patient, Blue Cross or Medicare. That per diem hospital costs are so stagg-

ering is a mystery to everyone except the administration. At present hospital services are very little more than room service in a not too good hotel. Ancillary needs of x-ray, laboratory, surgery, etc., pay for themselves. It may be that demonstrations by such hospitals as those in the Kaiser Foundation, indicating lower costs are possible, may lead to a more economical management.

Practically all hospitals now have a group of physicians known as the Bed Utilization Committee. Medicare uses this committee to check on hospitals and doctors to rule out "feather bedding." This group reviews representative Medicare charts to determine if the admission was for a bona fide ailment or was completely unnecessary. Of course the decision is simple in most instances; the fractured hip, the auto accident or cancer patient. On the other hand, some admissions defy decisions as to whether an arteriosclerotic patient with mild kidney trouble and milder diabetes must or must not be accepted as a Medicare admission. This is a question only the patient's own doctor can answer and not a review committee looking at a chart. The writer has served on two such groups at different hospitals and has never known of a Medicare admission to be questioned to the point of recommending refusal of aid to that patient. This is a decision the committee has not seen fit to make, no matter how often it may secretly feel the patient could just as well be cared for at home.

Is it any wonder hospital beds are at such a premium? True, medical practice *has* become more complicated and this demands more inpatient care, but there is much overuse and abuse. Who dies at home these days?

Lastly, the doctor is human and therefore not without blame. Before noting some of his Medicare failings it should be definitely remembered that the doctor and organized medicine fought this movement down to the last ditch. Smarting with accusations of self interest and patient neglect, the physician finally decided to join them for he could not beat them. Since then he, too, has gained undesirable traits.

Minor Surgery Now Done in Hospital

Most minor surgery formerly carried out in the office has now been transferred to the hospital. This was done for several reasons. It is much easier, for there is no worry about set up, materials, equipment and laboratory facilities. They are all furnished and handy. True, Blue Cross or Medicare must pay an extra $40 to $80 for that service but it costs nothing to the patient or doctor.

It also becomes a more important service to the patient than one performed in the office. The doctor learns early that removal of a mole or wart in the office brings in only a few dollars. The insurance fee allowed for the same procedure in the hospital is easily triple. If the surgery can be construed as a plastic removal or repair, the price is much higher still. The result is an obvious more frequent use of the hospital with increased cost to the patient and insurance carrier.

No surgeon is going to minimize what he does, for the larger the operation looks in the eyes of the clerk who reviewed the insurance or Medicare form, the more the surgeon is paid. Most doctors do not consider this dishonest since they feel the fees paid by the carrier are on the low side and should be raised, possibly by this means. Also, the surgeon resents being told how much a given operation should bring. Too often the insurance fee sets the standard price even for those quite capable of paying much more. There is nothing more simple than the removal of the usual early acute appendix. But with an abnormally placed appendix things can get pretty sticky. Add to this a ruptured appendix, and the best judgment and experience is demanded for some days. Yet, the fee paid the doctor is the same in all situations.

In the writer's area, un-needed operations are no problem. It is not doubted that they do occur and elsewhere this is common knowledge.

The first reaction to Medicare of the internist or general practitioner is apt to be resentment against regimentation and against the surgeon for having the better end of the deal. He has, therefore little compunction about taking what the traffic will bear. On the least excuse the oldster may be admitted to the hospital "for study" because of any infirmity. Who over 70 hasn't an infirmity—be it arthritis, dyspepsia or constipation? This, then, acts as a nidus which can be blown up into many days of laboratory and x-ray study. Who knows when to stop, for one of the tests might turn up some hidden ailment which no one had considered? There is no stopping in studying the patient completely. The patient's continued hospital stay is justified by tests still to come. The laboratory knows more when the usual ones wear thin.

Having patients in the hospital being tested or observed is a very convenient arrangement for the doctor. He can easily call on half a dozen in a matter of minutes where it would require half a day to see them in their homes. His charge for the hospital visit is reasonable—only a fraction of what Medicare is paying per diem to keep the patient there, but the doctor is in no hurry to distribute them to their various homes.

It is all free; who cares? Strangely enough, no one cares, including the taxpayer. Maybe he feels he will be the lucky one some day.

What can be done about the situation? Is there any answer or must we continue to pay more and more, getting less and less in return? Will the loopholes become larger with time? Will it be turned into an all-inclusive insurance plan which carries with it the same faults contained in Medicare?

It is contended that there is a way out of this morass which could lead to a better economic and permanent solution. Our solution is not one apt to be accepted because it does away with part of the cradle-to-the-grave promise. Too many want something for nothing, which is right up the Medicare alley.

The solution is a very simple one but a sure one. Ask every patient receiving Medicare to pay out of his pocket at the time, one quarter of every medical doctor's and hospital bill. This quarter of what Medicare allows must be paid at the time of service, out of pocket and not from supplementary insurance, which tends to perpetuate an undesirable situation. By this single move the patient would act as a committee of one (20 million!) to prevent overmedication and overhospitalization The outpatient status would be investigated and used when possible and the patient would learn in advance ways to decrease costs. It costs the patient if he doesn't. There is no incentive whatever for economy under the present system!

The obvious first rebuttal to this proposal is that the patient may have no money to pay his share. This inference that patients are turned away from our hospitals because of lack of funds is one used to glamorize free medical health programs. It simply is not true. The writer has never known of one patient who was turned away from any municipal or, for that matter, smaller county hospital because he had no money. This may not be true in certain areas in Appalachia but is true of the cities there. In spite of the unsavory recent reports about Chicago's Cook County Hospital, it cannot be denied that the *medical* care at that institution is superior to that in many of the carpeted private hospitals.

Costs can never be reduced so long as the patient doesn't care, the doctor doesn't care and the hospital doesn't care. With any form of prepaid insurance everyone is waiting to get back his share. If the patient were asked to pay from his own pocket at the time he receives his medical service, he would be a watchdog on the entire system, cutting corners and investigating leaks.

It must be understood that, under the present system, the Medicare patient *has* paid for his service through Social Security and, except for a few cents, through supplementary insurance. Therefore, if there is the least question of hospitalization, he wants to use this paid-up excursion to the fullest. He wants to be the lucky person for whom others pay. The attitude would be far different if part of the fare came directly out of his immediate pocket.

Recent changes suggested by Congress are a step in the right direction, but not far enough. We simply cannot afford to continue down the path taken in the past five years. After many years, the Heath government in Britain is attempting to alter the National Health Service with partial on-the-spot payments to increase incentives for self sufficiency.

While on the subject—the same criticisms of known wastes and loopholes may be leveled at the operation of Blue Cross-Blue Shield. It is even more pertinent with this organization, for coverage is often more complete. Paid-up policies result in the same indiscretions. A cure can only be obtained by removal of part of a prepaid clause. Such a change is not likely, since the patient wants "complete coverage," especially since the employer so often foots the bill. What everyone fails to realize is that the saving in premium would more than compensate and the result would be a more efficient economic situation with less waste of medical service. So the circle continues. ◄

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ABSTRACTS, BOOK REVIEWS

PSYCHOLOGY OF LANGUAGE

Dorsey, J. M., Center for Health Education, Detroit, 1971.

The book, Psychology of Language, suggests from its title that it will examine the psychologic basis of our speech. The book really does no such thing. Rather, it represents the ramblings in the general area of psychology and philosophy of a man who, by his credentials, should be well qualified to write a book on the psychologic basis of our speech. The book is full of such difficult to analyze statements as "Self wordy as my contribution to my literature may appear to me, I find it also my vigorous condensation of its lifesaving theme."

Perhaps the reviewer has missed the entire point of the book. He is, however, convinced that it will serve no useful purpose for the average practicing physician.

W. D. SNIVELY, JR., M.D.
Evansville

Abstracts from Various Literature, Prepared by AMA

DECISION TO NO LONGER LIVE ON CHRONIC HEMODIALYSIS

F. P. McKegney (Univ. of Vermont College of Medicine, Burlington 05401) and P. Lange

Am. J. Psychiatry 128:267-274 (Sept.) 1971.

Most patients receiving chronic hemodialysis consider withdrawing from it if the "quality of life" available to them or their families, or to both, is not sufficient. It would benefit most patients to openly discuss this option with the staff early in the program, thus making it a legitimate topic for discussion later when they may consider it more strongly. This procedure may decrease the morbidity and mortality of patients receiving dialysis.

WITHDRAWAL OF ANTIPARKINSON DRUGS

P. Orlov et al. (591 Morton St., Boston 02124).

Arch. Gen. Psychiatry 25:410-412 (Nov.) 1971.

Eighty patients who had been concomitantly administered antipsychotic and antiparkinson drugs for at least three months were withdrawn abruptly from antiparkinson medication. During the first three weeks after withdrawal, seven patients (nine percent) exhibited symptoms requiring them to be put back on medication. The remainder of the patients were still off antiparkinson drugs three months later. Ninety percent of patients simultaneously receiving antiparkinson and antipsychotic drugs may be discontinued from antiparkinson treatment after three months. This study replicates the findings of a previous study by DiMascio and Demirgian.

NOISE AND AIRCREW EFFECTIVENESS

W. R. Pierson (Lockheed-California Co., Burbank 91503)

Aerosp. Med. 42:861-864 (Aug.) 1971.

Aircrew effectiveness was equated with the ability to interpret display data (perceptual judgments) and to make correct decisions when the choices are few in number (intellectual judgment). Eight hours' exposure to 100 dB(A) aircraft cabin noise had no effect on perceptual judgment ability or on the time required for intellectual judgment. During the second four hours of the eight-hour exposure there was a significant increase in the number of errors committed in the intellectual judgment task. A significant shift in hearing acuity threshold occurred, but normal hearing was recovered within 48 hours.

ACUTE PHASE OF MYOCARDIAL INFARCTION

A. A. J. Adgey et al. (J. F. Pantridge, Royal Victoria Hospital, Belfast, Northern Ireland)

Lancet 2:501-503 (Sept. 4) 1971.

Dysrhythmias occurring within one hour of most of symptoms of acute myocardial infarction were documented in 284 patients. A high incidence of bradyarrhythmia was noted. Ventricular dysrhythmias were also frequent and showed a disappointing response to lidocaine therapy. Early initiation of intensive care not only prevents death from ventricular fibrillation, but also diminishes the incidence of shock and pump failure by preventing or immediately correcting dysrhythmias and limiting the size of the myocardial infarct. The resources for coronary care should be directed towards the pre-hospital phase.



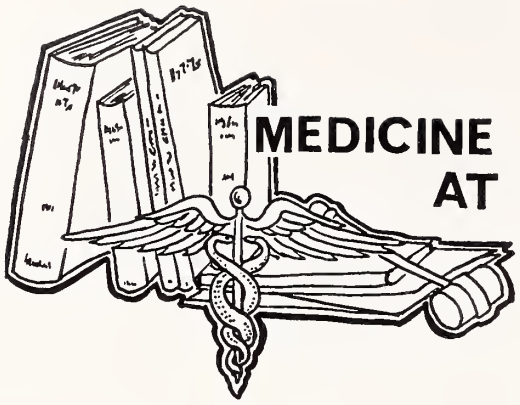
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MEDICINE AT LAW

Removing Bullet with Prisoner's Consent not Illegal Search—Surgeons who removed a bullet from a prisoner with his consent were simply performing a medical operation and there was no unpermitted invasion of his body, a Texas appellate court ruled.

The prisoner had been shot in an encounter that resulted in the death of another person, and the prisoner was charged with murder. The bullet removed from his body was used by the state for comparison purposes to show that it had been fired from the weapon of the deceased person.

The prisoner was tried and convicted of murder. On appeal, he contended that removal of the bullet from his body and its subsequent use by the police constituted an illegal search under the Fourth Amendment of the U.S. Constitution.

After the shooting, the prisoner had been taken to a hospital emergency room, where a detective advised him of his rights. He was placed under arrest and transferred to another hospital. An armed guard was stationed with him at all times.

Five days after the shooting, two physicians determined that the bullet should be removed to lessen infection and shorten the prisoner's hospital stay. They did not discuss the bullet removal with the police officers, except for asking that the handcuffs be removed.

After obtaining written consent for the operation from the prisoner, one of the physicians administered a local anesthetic and removed the bullet. A detective waiting outside the room asked for the bullet after the operation, and the physician marked it and gave it to him.

The prisoner also contended that removal of the bullet was a violation of his Fifth Amendment right against self-incrimination. He said that he was forced to waive that right at the trial in order to contest the legality of removal of the bullet. The appellate court pointed out that if the prisoner had chosen to testify about this matter outside the presence of the jury he would not have had to waive his Fifth Amendment rights.

He argued that he should have been warned that the physician would give the bullet to the police. The appellate court said there was no law prohibiting a person from giving the police an object that was lawfully in his possession. In this case, the bullet had been lawfully obtained from the prisoner.—*Webb v. State of Texas*, 467 S.W. 2d 449 (Tex. Ct. of Criminal App., June 2, 1971).

Physician Held Liable for Failure to Monitor Drug Side-Effects—When a patient died as a result of side-effects of treatment with methotrexate, his estate was awarded $200,000 by a Michigan jury. The award was against the physician who administered the drug. The hospital was held not liable.

The physician had given methotrexate to the patient for a total of 43 uninterrupted months as a treatment for psoriasis. The patient was taking two pills per day for five days, with two days off, and the dosage was sometimes as high as 32.5 mg per week.

About 30 months after treatment was started, spider angiomas developed. The physician failed to relate the angiomas to the treatment, even when they had increased after five months. Treatment with methotrexate was continued for about 11 months after the angimoas first appeared.

The patient was admitted to the hospital in February 1967, with a diagnosis of cirrhosis of the liver, probably secondary to a toxic condition induced by methotrexate. He died in June of that year.

Suit was brought against the company which manufactures the drug and, because the physician had since died, against his estate. The question of whether the drug company had given early enough and sufficient warning about liver damage was mitigated by the fact that the physician was carrying out studies for the drug company and knew that the drug might cause damage.

Although the physician's own studies indicated elevated serum glutamic-oxalacetic transaminase values, he monitored the patient's liver function only once in the 43 months of treatment. During extended medical and pharmacological testimony, none of the doctors testifying for either party could explain the doctor's failure to monitor the patient's liver function or to stop treatment with the drug when the spider angiomas appeared.—*Snell v. Curtis* (Mich. Cir. Ct., Wayne Co., Docket No. 119586, June 14, 1971).

Physician not Liable to Hospital for Cost of Settlement Agreement—After a hospital and two physicians settled a malpractice

claim and the patient's suit was dismissed, the hospital was not entitled to recover from one of the physicians its cost of settlement, a Georgia appellate court ruled.

The patient had brought an action for malpractice against two physicians and a hospital After filing an answer to the patient's complaint, the hospital then cross-claimed against one physician, contending that any negligence that existed was his. The cross-claim asked that the physician be required to pay to the hospital any sums that might be adjudged against the hospital and in favor of the patient.

Later, the hospital settled with the patient, paying certain sums in exchange for the patient's agreement not to sue. Subsequently, the two physicians also settled with the patient, and the case was dismissed.

Six months after the case was dismissed, the hospital sought to amend its pleadings in order to obtain judgment against the physician named in the cross-complaint for the money paid to the patient for his covenant not to sue. However, since the case was dismissed, no judgment had been entered against the physician, and the hospital had no basis for recovering its costs of settlement.—*Hospital Authority of Emanuel County v. Gray*, 181 S.E. 2d 299 (Ga. Ct. of App., Feb. 4, 1971; rehearing denied, March 5, 1971). ◄

New "Ten Commandments" Written By, For Vietnam Veteran-Patients

A new "ten commandments" was written recently by a group of Vietnam veteran-patients in the Veterans Administration psychiatric hospital at Brecksville, Ohio.

Young veterans serving on the hospital's Vietnam Era Committee, which advises the hospital staff on how to better serve the needs of younger veterans, drafted the "commandments."

The full text, below, brought applause when read by Dr. Elaine Heath, staff psychologist of the hospital, at the recent national meeting of the American Psychological Association, in Washington, D. C.:

OUR TEN COMMANDMENTS

I. Find yourself something to believe in - and be true to it.

II. Be fair. Yours isn't the only bag around, and yours isn't the only color.

III. Be free. Do what you want unless it hurts someone else.

IV. Use wisely. It's the only body you get.

V. Be strong. Don't compromise because of threats - or promises.

VI. Be peaceful. War destroys and gives no fair return.

VII. Try to understand. It's what you expect of them.

VIII. Share. Someone else might not ever experience what you have.

IX. Keep the faith. If they won't listen to us, we've got time on them.

X. Above all else, LOVE! It is the only commodity this world has a gross lack of.

"Positives rather than negatives are used," the patients added in a footnote, "because we are looking for positive action."

Blue Cross, Blue Shield Show Concern for the Individual

Ninety percent vs. 55%!

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They mean that your patients who were covered by Indiana Blue Cross and Blue Shield, on an *individual* basis, during the past year received a much higher return on their dollar for health care than those covered by the average competitor. A difference of 35% more, in fact.

Indiana Blue Cross and Blue Shield again returned more of its membership fee income to pay medical bills on an *individual* (direct pay) basis than any of the leading health insurers in the country last year, according to the 1971 Argus Chart of Health Insurance, a standard reference publication for the insurance industry.

The percentage of income returned in health care benefits is widely accepted as the most important test as to what extent the customer is getting his money's worth.

Average Payout 55%

During 1970 Indiana Blue Cross and Blue Shield continued to do a much better job for direct pay members than was done by private companies for their *individual* members by paying out in benefits 90% of each direct pay membership fee dollar received. In comparison, the average payout for leading private insurance companies was less than 55% for their *individual* hospital and medical coverage.

The leading 90% figure returned by Indiana Blue Cross and Blue Shield was for *individuals* under 65 years of age and does not include Medicare Supplement.

No One Refused Coverage

The percentage of income returned to members by Indiana Blue Cross and Blue Shield reflects a long standing concept of making coverage available to anyone, regardless of age or health. Blue Cross and Blue Shield have always been concerned with the *individual* persons who have been unable to obtain health insurance from other companies. Indiana Blue Cross and Blue Shield, in their more than 25 years of operation, have taken pride in never refusing coverage to anyone.

Blue Cross and Blue Shield believes that money paid in for health care should be paid out for health care, and operates on that basis. This policy is especially important in the area of *individual*, direct-paying members.

Nearest Competitor 64%

The nearest competitor to the 90% returned by Indiana Blue Cross and Blue Shield on an *individual* basis was 64%, and the figures from a list of 17 health insurers earning more than $100 million during the year throughout the country ranged downward to a low of 39% payout for *individual* policies. Only five of the major companies surpassed or even reached the 60% returned figure.

The record of private companies selling *individual* (direct paying) hospital and medical coverage is not good. They are dealing with *individuals* who are unable to determine the value of the insurance they are buying and are attracted by seemingly low fees. Included among those furnished this type of coverage are those with the greatest need for adequate protection at a minimum cost—the elderly and the people of low income.

Under some forms of widely promoted commercial health insurance, *individuals* not eligible for group coverage often find their protection not only costly but grossly inadequate. In addition, the percentage of their health care dollar used for actual payment of benefits is often shockingly low.

For example, in 1970 three private companies with the poorest performance paid out less than 50 cents of each dollar received. This type of performance is reported year after year, and millions upon millions of dollars paid in for health care are never paid out for health care.

It is Blue Cross and Blue Shield policy to furnish maximum benefits to the *individual* for the lowest possible fees, and to make available adequate protection to the full range of the population—good risks and bad. Blue Cross and Blue Shield believe this approach is the best solution to the problem of financing health care for the people of Indiana, and the proof is in the performance. ◄

TAX TIPS



by LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

THERE is still time to establish a qualified retirement plan so as to provide yourself with an income tax deduction for the current year for the contributions which you make to the plan. As I am sure you know by now, the earnings on your contributions to the plan are exempt from income taxation as they are earned, and there are some income tax advantages when the contributions and earnings are withdrawn from the fund at your retirement, either as a lump-sum distribution or as an annuity. If you intend to organize a professional corporation and utilize one of the qualified plans available to corporations, then you definitely should discuss your situation with your lawyer. But do it now, so that you have the opportunity to make a decision before the end of the year.

Another point. Do you know what is the last day of 1971 on which a cash method taxpayer may sell corporate stock over the New York Stock Exchange in order to have the gain or loss recognized in 1971?

Since a cash method taxpayer does not report gain until he actually or constructively receives the proceeds from a sale, the answer to the question for gain purposes is affected by the period of time that the stockbroker has, under stock exchange rules, to deliver the cash to the taxpayer. The New York exchange requires the broker to deliver the proceeds within five business days after the sale date. Thus, a taxpayer may sell his corporate stock on or before Friday, December 24, 1971,* and recognize a gain in 1971. If he sells his stock after Friday, December 24, 1971, then his gain will be recognized in 1972, unless he requests that his broker accept a cash sale, in which case the sale could be made as late as December 31, 1971, because the broker would be required to deliver the cash to the taxpayer on the date of sale.

If the cash method taxpayer has a potential loss on his stock, he is unaffected by the stock exchange rules concerning cash delivery. I.R.C. section 165 allows a loss deduction in the year that the loss is incurred, regardless of when the sale proceeds are received. Thus, if stock is sold at a loss as late as December 31, 1971, the loss must be recognized in 1971, regardless of when the proceeds are delivered to the taxpayer.

In any event, before selling any stock at a loss during 1971, remember that if you have an excess of long-term capital losses over your capital gains, then you may lose a deduction for 50% of the excess. Thus, if you can recognize capital gains to eliminate the excessive long-term capital losses, do so. Otherwise, consider delaying the recognition of your long-term capital losses until 1972, when you will have another opportunity to recognize some capital gains.

Note—this date may be changed to an earlier date by the New York Stock Exchange for the year 1971.

Another tip, as January approaches, concerns corporations. If calendar year corporations want to elect to be taxed under Subchapter S of the 1954 Code for their taxable years beginning January 1, 1972, then they must file their election statements (I.R.S. Form 2553) on or before January 31, 1972. In general, the shareholders also must file their consent statements on or before January 31, 1972. However, because of the recent changes concerning the amount of income on which a shareholder-employee will be taxed, due to a corporation's contribution, on his behalf, to a qualified retirement plan, it may be wiser not to elect Subchapter S. Further, Subchapter S corporations may want to terminate their Subchapter S elections now.

Have a merry year-end. ◄

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The Woman's Auxiliary

REPORTS TO ISMA

As I write this the Holidays are just around the corner. During this Christmas season:

May you have the Spirit of Christmas, which is Peace,
The Gladness of Christmas, which is Hope,
The Heart of Christmas, which is Love.

This is the first opportunity I've had to tell you about the state convention. All of the women's activities were very well attended. There was a tea on Tuesday afternoon, Oct. 12, at the lovely home of Dr. and Mrs. Donald McCallum. Mrs. Buchman Gardner provided beautiful harp music during the tea.



On Wednesday, Oct 13, there was an open board meeting. Both Dr. Pete Petrich and Dr. James Gosman dropped in to say Hello. We thank you for coming, you are always welcome. We learned that Dr. William M. Sholty of Lafayette has been appointed as the new liaison officer to the Woman's Auxiliary.

At the luncheon in the Hilton Hotel we were honored to have as our guest Mrs. Wesley W. Hall, Reno, Nevada, wife of the AMA president. Other guests included Mrs. Malcolm Scamahorn, wife of the ISMA president, and Mrs. Pete Petrich wife of the ISMA president-elect. Mrs. John Pitman, chairman of the women's activities for the convention, introduced the luncheon speaker, Dr. Ephraim T. Lisansky of the University of Maryland. Dr. Lisansky gave a very interesting talk on "The Changing Patterns of Medical Illness." He indicated that human behavior—and misbehavior—are responsible largely for the changing patterns of medical illness. Dr. Lisansky stated that, "In view of these new patterns, a doctor's job has changed and with it the job of the doctor's wife has changed." He also stated that there's nothing more psychosomatic than suicide. Suicide was cited as the second most frequent cause of adolescent death in the U.S. In addition to suicide, Dr. Lisansky held that human behavior also influences medical illnesses, including cancer. Concerning lung cancer he said, "smoking has a lot to do with it—as does our polluted atmosphere." He indicated that when women began smoking their rate of lung cancer increased to that of men.

The Eli Lilly Company provided busses that took the ladies to the new Indianapolis Museum of Art. They were returned to the hotel in time to dress for the President's reception, which was followed by a dinner. After dinner we were entertained by the "Belles" from Indiana University.

The convention chairman, Dr. S. O. Waife, did a fine job; it was a pleasure working with him and with my own convention chairman, Mrs. John Pittman. A big thanks to you both from all the ISMA and the WA-ISMA.

Lelia M. Chernisky



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Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., certain elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—they can both cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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Refresher Course in Family Practice

(Originally scheduled for Jan. 11, 13)

March 7, 8, 9, 1972—Indianapolis

Designed to prepare the physician for the American Board of Family Practice examination, this three-day course will review all areas of Family Practice. Also, participants will gain experience with the specific testing modalities used in the Board Examination. The course will be patterned after suggestions made by the American Board of Family Practice and the American Academy of Family Practice.

Director: Dr. A. Alan Fischer, Associate Professor and Director of Family Practice Program.

Management of Youthful Drug Users

April 5, 1972

As drug abuse increases among youth, more physicians see such patients in their offices, in clinics, and in emergency rooms. This represents a new diagnostic and therapeutic experience, and physicians seek management tools for various drug reactions — drug intoxication, drug overdose, bad trips, and flashbacks. And the problem of treating a minor who does not wish his parents to know about his drug habit can prove vexing. Then beyond the acute emergency of the youthful drug user lie more basic problems of child/parent conflict and identity crisis on the part of the user.

This course seeks to provide information and understanding which will aid the physician caring for these patients and their families.

Director: Dr. Ivan F. Bennett, Associate Professor of Psychiatry.

Current Topics in Internal Medicine

April 5-6, 1972

This course, Current Topics in Internal Medicine, is designed for practicing internists and those persons preparing for the examination of the American Board of Internal Medicine. The two-day review will also be of value to the general physician who wishes more intensive exposure to problems encountered in internal medicine.

The course will cover both theoretical and practical aspects of selected topics within the broad framework of hematology, cardiology, endocrinology, nephrology, pulmonary disease, gastroenterology, allergy, and infectious disease.

Director: Dr. Walter J. Daly, Chairman and Professor of Medicine.

Infectious Diseases

April 19, 1972

This six-hour course will outline the changing pattern of organisms encountered in clinical disease and the alterations in host resistance which increase susceptibility to infection. The faculty will review the newer antimicrobial agents and their appropriate regimens.

Director: Dr. Arthur White, Professor of Medicine.

The Third Annual Emergency Trauma Care Symposium

April 20, 1972 — Lafayette, Indiana

This course is designed to review for the practicing physician certain principles of emergency medical care. Featured topics will include: 1) management of the patient in shock — different viewpoints on the diagnosis and management of shock; 2) initial management of trauma from electrical shock or lightning — a panel discussion by surgeons and internists; 3) forensic medicine from the standpoint of the toxicologist and the coroner.

Director: Dr. Lindley H. Wagner, Director of Medical Education, St. Elizabeth Hospital.

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512 East Minnesota Street
Indianapolis, Indiana 46203

FUTURE MEETINGS, SEMINARS, COURSES

Four-Day Refresher Course Set

A four-day refresher conference for the family practitioner of medicine will be held at The University of Iowa Health Center in Iowa City, Tuesday thru Friday, February 15 to 18. Content of the program has been determined mainly by suggestions from physicians and the Iowa Academy of Family Practice. Early registration is advised. Write Office of Medical Education, The University of Iowa, Iowa City 52240.

Texas Medical Assembly to Meet

The International Medical Assembly of Southwest Texas will hold its 36th annual meeting on February 17 and 18 at the Gunter Hotel in San Antonio. After the two-day convention a postgraduate seminar will be held in the Grand Bahamas. The entire program is acceptable for accredited hours by the AAFP. Write the Assembly at 202 W. French Place, San Antonio 78212.

Colorado Offers Hand Surgery Course

"Surgery of the Hand" will be the subject of a postgraduate course to be conducted by the University of Colorado School of Medicine in Denver on February 23 to 26. Tuition is $100. Write Office of Postgraduate Medical Education, 4200 E. Ninth Ave., Denver 80220.

Surgeons to Conduct Three Sectional Meetings

The American College of Surgeons will conduct three sectional meetings in 1972: Jan. 17 to 19 at Miami, Feb. 14 to 16 at St. Louis, and March 13 to 15 at Philadelphia. All doctors of medicine are invited to attend. Each meeting features sessions in general surgery plus two or more surgical specialties. Top-flight teachers will focus attention on new ways of handling surgical problems through panels, symposia, "How-I-Do-It" clinics, scientific papers and selected films. The registration fee for non-Fellows is $15. For official hotel forms and programs write the College at 55 E. Erie St., Chicago 60611. ◄

About Our Cover

The "red ball rescue program" designed to assist in the rescue of children and invalids trapped in burning houses is receiving wide acceptance throughout the country.

The Indianapolis Firefighters Association and the Indianapolis Fire Department began the program recently. Red ball stickers, four inches in diameter, are available at the 35 city fire stations. The stickers are to be placed on windows of bedrooms occupied by children and invalids, so firemen can locate the rooms as soon as they arrive at the scene for quick rescue.

Bulletins and posters are being distributed through elementary schools, encouraging children to obtain the stickers.

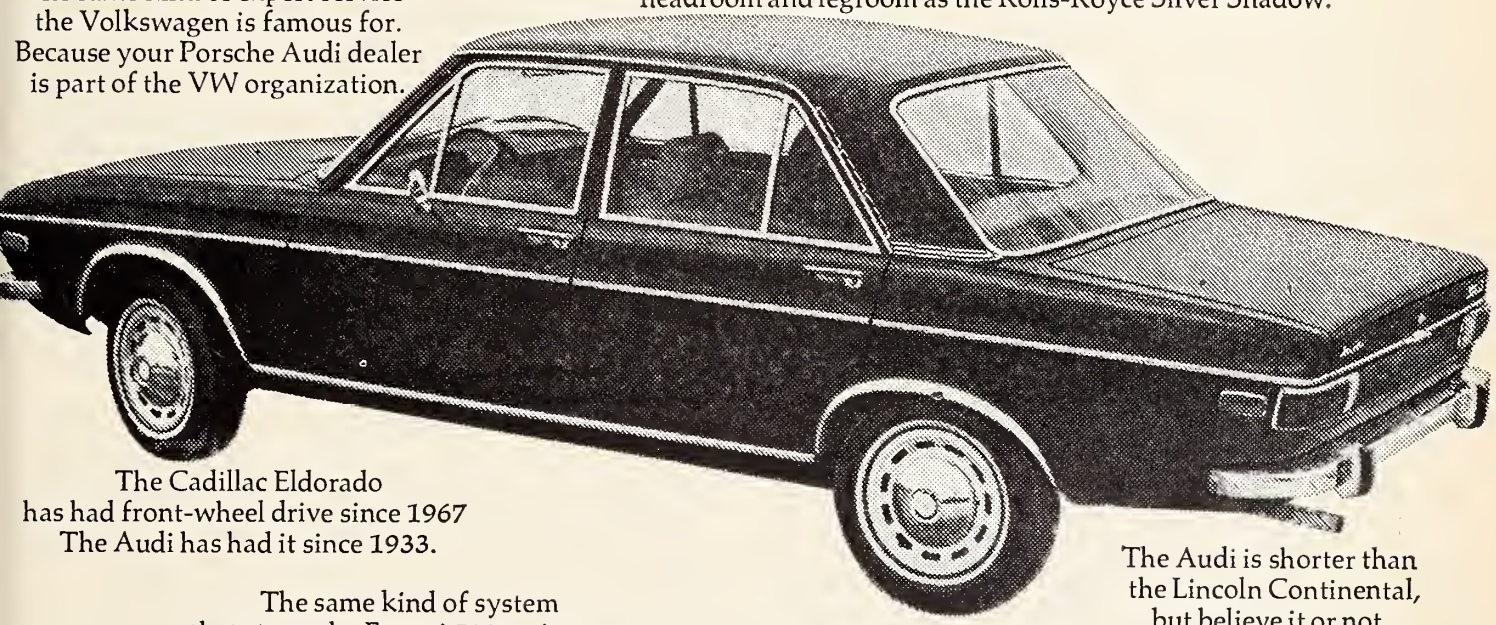
American Red Ball Transit Company, Inc., headquartered in Indianapolis, is providing the stickers as a public service.

TEST DRIVE 7 CARS

You can hardly
spot the difference between
the interior of the Audi
and that of the Mercedes-Benz 280SE.

The Audi gets
the same kind of expert service
the Volkswagen is famous for.
Because your Porsche Audi dealer
is part of the VW organization.

The Audi has the same
headroom and legroom as the Rolls-Royce Silver Shadow.



The Cadillac Eldorado
has had front-wheel drive since 1967
The Audi has had it since 1933.

The same kind of system
that steers the Ferrari 512 racing car,
steers the Audi.

The Porsche 917 racing car
has *inboard* disc brakes.
So does the Audi.

The Audi is shorter than
the Lincoln Continental,
but believe it or not,
it has just as much trunk space.

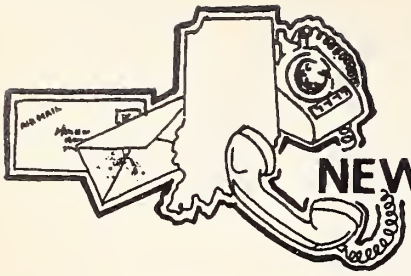
The Audi 100LS

PORSCHE | AUDI
a division of Volkswagen

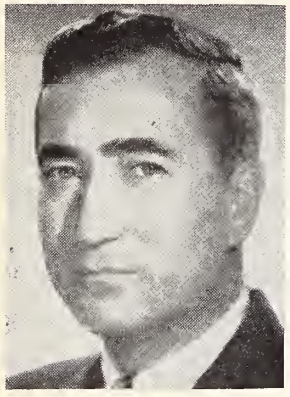
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Kline Porsche Audi, Inc.
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Putnam Imports
2200 Bypass Road, Elkhart



Dr. Gosman Named President-Elect



Dr. James H. Gosman, Indianapolis, was named president-elect of the Indiana State Medical Association at its 122nd annual convention in October. A dermatologist, he has been in private practice in Indianapolis since 1949 and is an associate professor of internal medicine, at the Indiana University School of Medicine's department of dermatology.

A native of Jasper, he is a graduate of the Indiana University School of Medicine and served as a Flight Surgeon with the U.S. Air Force for five years, seeing service in North Africa, Italy and Germany.

He has served the ISMA as alternate delegate to the American Medical Association and on the Board of Trustees and various Commissions. He is a past president of the Marion County Medical Society, is president-elect of the Indiana Division of the American Cancer Society, and serves as an officer or director of many other civic, health and medical organizations.

FDA Issues Final Regulations On Fixed Combination Drugs

The FDA has issued regulations in final form concerning fixed combinations. The main points are:

1. A fixed combination product may not be marketed unless it offers the patient a therapeutic advantage over any of the components administered separately, subject to modification as below.

2. Two or more drugs may be combined in a single dosage form when each contributes to the claimed effects. Dosage of each ingredient must be safe and effective for a significant number of patients who require concurrent therapy with the drugs. Also acceptable will be combinations that (a) enhance safety or effectiveness of the principal ingredients, or (b) minimize potential for abuse of the principal ingredient.

3. If a licensed combination is changed to meet requirements set by National Academy of Sciences — National Research Council proposed formulation, labeling or dosage changes may meet the new requirements.

4. Requirements are met if a combination is judged effective by FDA on NAS-NRC studies. All "over-the-counter" preparations are exempt from the regulation.

Dr. James Bennett Named To ACS Board of Governors

Dr. James E. Bennett, Indianapolis, was named to a three-year term as Governor of the American College of Surgeons at the recent Clinical Congress of the College. In all, 26 new members of the Board of Governors were elected, bringing the number of Governors to a total of 189. **Dr. Joseph B. Davis, Marion,** who is the other Governor for Indiana, has been a member of the Board for several years.

MEDCOM Program on Hypertension Offered

Merck, Sharp & Dohme has originated a three-part learning system on hypertension. It consists of a teaching film, a book titled "Hypertension—A Mosaic in Medicine", and a self-evaluation test form. Dr. Irvine Page has written the introduction to the book. Booking forms for the film are available from Merck, Sharp & Dohme representatives, or inquiry may be directed to Dr. Ralph E. Snyder, Merck, Sharp & Dohme, West Point, Pa. 19486.

Takes Blue Cross Post

Dr. Lee M. Cattell, Jr., Kokomo orthopedic surgeon, has been appointed medical director of the medical review department of the Indiana Blue Cross Plan.

A diplomate of the American Academy of Orthopaedic Surgeons, Dr. Cattell has served as orthopedic consultant to Grissom Air Force Base and chief of surgery at St. Joseph Memorial Hospital and Howard Community Hospital, Kokomo.

Medical Center Studies, Treats Hodgkins Disease

The Department of Hematology, Indiana University School of Medicine, has a special service for the study and treatment of Hodgkin's disease. Referrals of newly diagnosed patients or patients previously treated who exhibit active disease are invited. Write or call Dr. Lawrence H. Einhorn, Department of Hematology, Emerson Hall, 1100 W. Michigan St., Indianapolis 46202.

Radiologist Speaks to Seniors

Dr. C. Robert Plank, Michigan City, was guest speaker for the recent ceremony at which students beginning their senior year at the Northern Indiana School of Radiologic Technology were honored.

Health Board Issues Coho Salmon Warning

Recent samples of Coho salmon taken from the state weirs by personnel from the Department of Natural Resources, were found to contain polychlorinated biphenyls (PCBs) in excess of the tolerance set by the US Food and Drug Administration, Dr. A. C. Offutt, State Health Commissioner, announced recently.

Dr. Offutt pointed out that all available evidence indicates that PCBs are less toxic than DDT, which is one of the safest of pesticides in terms of acute toxicity. However, since long-range feeding studies have not yet been completed, the chronic toxic effects of PCBs have not been established.

In view of the moderate toxicity of PCBs and the fact that sport-caught fish are a less significant food resource than commercially-caught fish, the use of the Coho salmon returning from Lake Michigan should be avoided as a staple food source.

Dr. Offutt emphasized that these results were based on a relatively small sample of fish and that the cooperative efforts with the Department of Natural Resources in the collection and analysis of additional samples will be continued and expanded.

Dr. Leslie Bodnar to Participate in Sports Medicine Program at Notre Dame

Dr. Leslie M. Bodnar, South Bend, will be on the medical portion of the program of the American Football and Basketball

Conference which will be held at the University of Notre Dame on March 23 to 26. Physicians interested in sports medicine are invited to attend the Conference. Full details may be obtained by writing the Notre Dame Center for Continuing Education, South Bend.

New Dow General Manager Named

Robert J. House has been named general manager of the Indianapolis Division of Dow Chemical Company (formerly Pitman-Moore). Mr. House has been with Dow for 30 years and has served as controller and industrial relations manager and recently as manager of financial and personnel services.

ARS Elects Dr. D. S. Chamberlain

Dr. Donald S. Chamberlain, South Bend, was elected to membership in the American Roentgen Society at the organization's annual meeting in Boston recently.

Announces 1972 Medical Tours To Africa and Scandinavia

Dr. Wei-Ping Loh, Gary, has been working on medical programs for 1972 African tours beginning January and Scandinavian tours beginning May. Each tour will involve a two-week air trip.

The African tours will be participated in by 12 state medical societies and are comparable to those conducted in 1970. There will be visits to Morocco and Kenya. The Scandinavian tours will be participated in by 21 medical groups. There will be visits to Stockholm (with optional extension to Oslo), Helsinki (with optional extension to USSR) and Copenhagen. The Indiana State Medical Association group will depart on May 24, 1972. There will be medical meetings at each major stop. The Kenya Medical Association and Finnish Medical Association have already agreed to participate in the medical programs. Anyone who can recommend speakers in those foreign cities should contact Dr. Loh for additional arrangements.

The Orient and South Pacific medical tours will continue as usual in 1972. A return to South America for more medical tours has been planned for 1973.

Speaks on Inherited Emphysema

Dr. R. N. Matzen, director of clinical research at the Caylor-Nickel Clinic, Bluffton, addressed a joint meeting of the Howard County Tuberculosis and Respiratory Disease Association and the Kokomo Rotary Club recently. He discussed inherited emphysema.

Conference Proceedings Offered

The Proceedings of the Anglo-American Conference on Medical Care is now available from the Royal Society of Medicine, co-sponsor of the Conference. Experts on the subject from the British Isles and from the United States met in London April 5 to 7. The Proceedings report their original papers and the discussion which followed. Participants from the U.S. included Drs Jesse L. Steinfeld, Walter C. Bornemeier, and John H. Knowles. Elliott L. Richardson and Wilbur J. Cohen also spoke. Mr. J. Enoch Powell was one of the many British participants. The Proceedings may be obtained by writing the Society at 1 Wimpole St., London W1M 8AE. The price per copy is $5.00 plus $2.00 postage.

Gary Methodist Hospital Honors Six for Quarter-Century Service

Six area physicians received recognition recently for serving 25 years with the Gary Methodist Hospital medical staff.

The men, who were presented with 25-year special award certificates for "continuous and dedicated service to Methodist Hospital," are: **Drs. Jerome Korn, Walfred A. Nelson, Louis W. Parratt, Simon S. Rubin, George F. Slama and William Yocum.**

Dr. Reginald R. Barton has been elected new medical staff president succeeding **Dr. Marvin R. Bernard.**

Speaks on Birth Control

Dr. C. David Ryan, Columbus, gave a talk on birth control at a recent meeting of the Pre-school Mothers Club of Seymour.

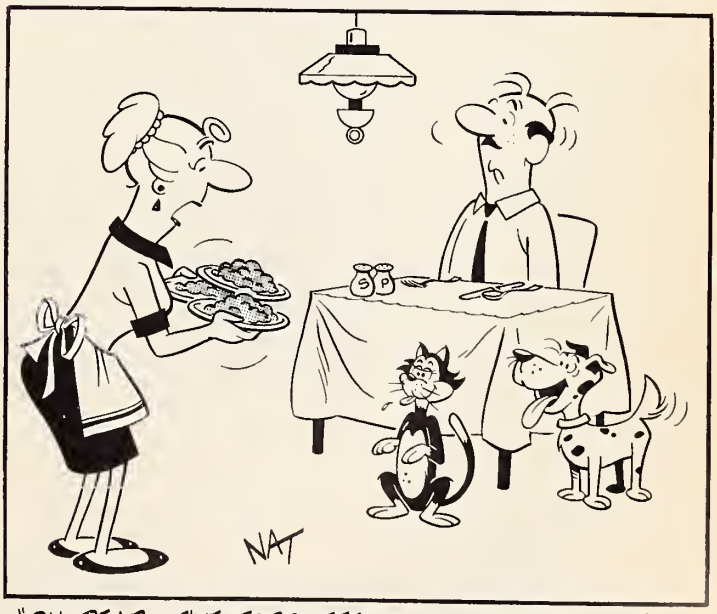
Record Breaking Number of Medical Assistants Certified

The American Association of Medical Assistants announces that a record number of medical assistants have passed the 1971 certification examination. Of the 169 certificates earned, 77 were clinical certificates, 52 were administrative and 40 were dual. In Indiana Mrs. Jean A. Cox of Clarksville, Mrs. Betty F. Henderson of Bedford and Mrs. Marlene E. Katzman of Mulberry received clinical certificates and Mrs. Mary Haugen of Fort Wayne received an administrative certificate. Those earning the CMA distinction were honored at a dinner during the organization's annual meeting in Atlanta in November. Mrs. Marie Young of Indianapolis was the AAMA president for 1970-71. She has been succeeded by Mrs. Helen Stephens of Ogden, Utah.

Drs. Shumacker, Richardson on Program

Dr. Harris B. Shumacker, Jr., Indianapolis, and Dr. Joseph A. Richardson, Fort Wayne, were featured speakers at the 80th annual meeting of the Association of Life Insurance Medical Directors recently. Dr. Shumacker discussed the actuarial implications of major heart surgery and cautioned against an overly optimistic forecast for the distant future despite apparently near perfect results immediately. Dr. Richardson discussed the recent improvements in the treatment of hemophilia and outlined the clinical data necessary for a realistic appraisal of life expectancy.

Continued



"OH, DEAR...I'VE FORGOTTEN WHICH WAS WHICH!"

Continued

Physicians Named to Council

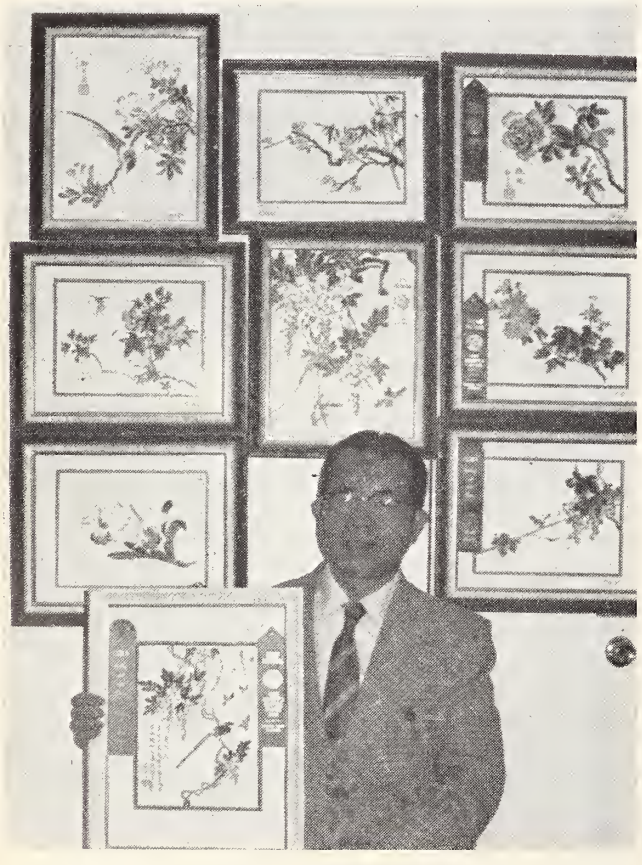
Three physicians were among those named to a 21-member developmental disabilities advisory council by Gov. Edgar D. Whitcomb recently.

They are: **Dr. Walter E. Deacon, Indianapolis,** director of state services for crippled children, **Dr. Verne K. Harvey, Jr., Indianapolis,** director of the State Board of Health's bureau of special health services, and Dr. William E. Murray, Indianapolis, the state mental health commissioner.

The council will plan and review programs under the federal developmental disabilities act, which provides funds in such areas as mental retardation, epilepsy and celebral palsy. Indiana is to receive $248,740 for the program this year.

PMA Awards Total $200,000

The Pharmaceutical Manufacturers Association Foundation recently awarded more than $200,000 for research and education projects in U.S. colleges and universities. The largest grants include funding for three research projects and one workshop. In addition, two-year fellowship awards will go to six scientists for work in pharmacology-morphology. Also, 14 medical students were granted $1,000 stipends as trainees in clinical pharmacology. This makes a total of 94 such trainees who have been funded in the five-year history of the Foundation.



DR. Wei-Ping Loh, Gary, is shown with the nine watercolor paintings on silk which he exhibited at the ISMA Art and Hobby Show at the 1971 convention and at the Central States Fair held at Crown Point recently. Five of the nine paintings received awards.

The "Birthday Bird" painting which he is holding received first award at both exhibits. The other awards include three second place and one third place.

Dr. Loh learned painting from a private teacher in Taipei in May and June of this year when he served as a Visiting Professor of Hematology at the National Taiwan University.

Mead Johnson Affiliate Gets Drug Identification Contract

Biochemical Procedures, a national clinical laboratory of North Hollywood, California, has been awarded a contract by the U.S. Army to conduct a drug identification program for servicemen. Urine samples will be tested for morphine, barbiturates, amphetamines and methadone. A major portion of the laboratory's new building in California will be utilized for these analyses. Biochemical Procedures is an affiliate of Mead Johnson.

Elected Health Board Chairman

Dr. Parker W. Snyder, Peru, was recently re-elected chairman of the Miami County Board of Health.

S.S. Hope to Sail for Brazil

The S.S. Hope has returned to Baltimore following a 10-month mission in the West Indies. Hope is initiating a five-year program of postgraduate education at the University of the West Indies to ease the brain drain which results from about 40% of the personnel who are training at the University migrating to other countries for graduate studies. After repairs and re-supply the ship will sail for Natal, Brazil, in February. She will go to Venezuela in 1973.

Veterans Administration Honors Two "Distinguished Physicians"

Barnes Woodhall, M.D., James B. Duke Professor of Neurosurgery at Duke University, Durham, N. C., and Brian Blades, M. D., Chairman of the Department of Surgery of George Washington University, Washington, D. C., have been named Veterans Administration Distinguished Physicians.

The appointment, for three years, is one of the highest honors the VA bestows, and only three others had been named previously. It carries a yearly salary of $36,000 on a fulltime basis.

The program was established in 1968 to enable the VA to use the talents of outstanding medical scientists and educators. The Distinguished Physician is assigned as a member of a VA hospital staff but provides scientific and educational consultation and leadership on a VA-wide basis.

Dr. Woodhall has had a long and distinguished career in academic medicine which began with his appointment to the Duke University School of Medicine faculty in 1937. He has served on numerous national and international committees and on the Special Medical Advisory Group to the VA Administrator and Chief Medical Director.

Dr. Blades is an internationally renowned surgeon and teacher who has pioneered in the field of thoracic surgery.

When the VA Department of Medicine and Surgery was established in 1946, Dr. Blades was selected to advise and assist VA in establishing the organization and standards of professional care for veterans in the area of thoracic surgery.

He served for many years as a VA consultant and on the VA Special Medical Advisory Group.

The three previously appointed VA Distinguished Physicians are William B. Castle, M.D., of Harvard University, Tinsley R. Harrison, M.D., of the Medical College of Alabama, Birmingham, Ala.; and William S. Middleton, M.D., of Madison, Wis., the former VA Chief Medical Director and Dean Emeritus of the University of Wisconsin School of Medicine.

New Public Affairs Pamphlet Discusses Nutrition, Diet

"Vitamins, Food, and Your Health" is the latest Public Affairs Pamphlet. It is a 28-page discussion of nutrition and how to obtain a proper diet. Written for the laity, it is sold at the rate of 25 cents a copy with discounts for quantity. Write Public Affairs Pamphlets, 381 Park Ave. South, New York City 10016.

Supervises Ambulance Attendant Test

Dr. Harry G. Becker, Indianapolis, administered the tests given recently for the newly formed National Registry of Emergency Medical Technicians—Ambulance. These were the first such qualification tests for Indiana ambulance attendants.

Named Executive of AAFP

Roger Tusken has been named executive director and convention manager of the American Academy of Family Physicians. He has been assistant executive director since 1968 and succeeds Mac Cahal, who retired recently as executive director but remains with the Academy as general counsel.

Inner City Problems Topic

Dr. E. Henry Lamkin, Jr., was one of the speakers at a symposium on community health at a Marion County Tuberculosis and Respiratory Disease Association board of directors meeting recently. He is to be the director of a comprehensive health center planned for the inner city of Indianapolis. ◄

★

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Professional Protection Exclusively since 1899

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What's New?

Lederle is introducing a new antibiotic—a semi-synthetic named MINOCIN® (minocycline HCl). It is a tetracycline which during clinical trials has not shown any tendency toward photosensitivity. Effective against both gram-negative and gram-positive organisms. The recommended dosage is two 100 mg capsules initially followed by 100 mg every 12 hours.

Minocin®, has been demonstrated to be effective against some strains of staphylococci which are resistant to other tetracyclines. Other diseases and organisms against which Minocin is effective are shigella, pneumococcal pneumonia, typhus fever, psittacosis, lymphogranuloma, Rocky Mountain Spotted Fever, and Vibrio comma. It is also effective against N. gonorrhea.

* * *

Eli Lilly is providing a new and smaller size of Cordran tape. The new size is 24 inches by 3 inches to provide lower-cost initial therapy. The standard length of 80 inches is continued.

* * *

LIDEX® is a new topical corticosteroid developed by Syntex. The FDA has approved it for marketing in the U.S. It consists of fluocinonide in Fatty Alcohol Propylene Glycol base. It is indicated for psoriasis, atopic dermatitis and other corticosteroid-responsive dermatoses.

* * * *



The Bio Data Medical Instruments Division is featuring a new Magnetic Sound Amplifying Stethoscope. It weighs less than 3½ ounces, operates on a magnetic amplifier and requires no batteries. Volume is controlled by varying the amount of pressure applied to the stethoscope body.

* * * *

General Electric is offering a free "site survey" questionnaire to hospitals for the purpose of allowing the hospital to recognize and identify information storage and retrieval problems. After completion, the questionnaire is analyzed by GE management specialists and recommendations are made. Contact GE Medical Systems Dept., 4855 Electric Ave., Milwaukee 53201.

* * * *

The J. T. Baker Chemical Company offers narcotic detection kits. They are small and can be carried in a pocket or glove compartment. One of the kits tests for marijuana; another for cocaine, Demerol and methadone; still another for opium, heroin or codeine, and the fourth tests for morphine, amphetamines and mescaline. Each one is applicable to confiscated material the nature of which is unknown. The kits include instructions for use and each one sells for less than $2.00.

* * *

The Aluminum Company of America has a "Stand-Up Wheelchair," which won special recognition in the Company's design program. When the occupant wishes to stand, he leans forward, grasps two knobs, one on each chair arm, and pushes. Springs, adjusted to the patient's weight, then automatically release the seat and raise the patient to a position only 10 degrees from vertical. At the same time the footpads drop to provide a firm base for standing. The process is reversed by a releasing mechanism.

* * *

A. H. Robins is introducing Robicillin VK™, a brand of potassium phenoxymethyl penicillin for oral use. It is available in 250 mg and 500 mg tablets, and in oral solutions 125 mg or 250 mg per 5 ml. 250 mg is the equivalent of 400,000 units.

* * *

Wilcom is publishing a reference book to provide physicians with the retail prices of the most commonly prescribed brand name and generic drugs. "Physicians' Guide to Prescription Prices" lists average prices for dosage units in the most commonly prescribed quantity.

* * *

Upjohn has a new antibiotic—Trobicin—which is chemically unique and is used specifically for treating acute gonorrhea. Strains of the gonococcus which have multiplied as a proportion of the total due to resistance to other antibiotics have been found to be susceptible to Trobicin. It is not recommended for the treatment of syphilis. The recommended dose is one intramuscular injection of 2 grams for men. For women, the dose is 4 grams, usually two injections given at the same time.



Campbell's Soups... wide variety...for limited appetites

Many people lose interest in food as they grow older. Some of them are fussy eaters—with only a few favorite foods. Others become indifferent to foods—because planning and preparing meals becomes a chore. Here Campbell's Soups can help —for these four very good reasons:

Appeal With a variety of tastes, textures, aromas, and colors, Campbell's Soups can add interest and appetite appeal. And they're easy to eat—ingredients are tender, bite-size. Many patients on special diets will find soups they can enjoy among the more than 50 different varieties available.



Nourishment Campbell's Soups contain selected meats and sea foods, best garden vegetables—carefully processed to help retain their natural flavors and nutritive values.

Convenience Within 4 minutes a bowl of delicious soup is heated and ready to eat.

Economy Campbell's Soups are inexpensive—an important consideration to those whose budgets are limited.

Recommend Campbell's Soups . . . and, of course, enjoy them yourself. Remember, *there's a soup for almost every patient and diet . . . and for every meal.*

When diarrhea wrings the wedding belle...



It's all very well to counsel patience in diarrhea patients. There are times when relief of symptoms can't come too soon.

X-ray studies[1] in 16 normal subjects showed just how promptly the active ingredient in Lomotil does its work.

Lomotil retarded gastrointestinal motility particularly during the first three hours after administration. It continued its moderating action on the bowel for at least three hours more.

Physicians prescribe Lomotil more often than any other drug when the urgency for the control of diarrhea is most distressing.

1. Demeulenaere, L.: Action du R 1132 sur le transit gastro-intestinal, Acta gastroent. Belg. **21**:674-680 (Sept.-Oct.) 1958.

Lomotil®

TABLETS/LIQUID

Each tablet and each 5 cc. of liquid contain:
Diphenoxylate hydrochloride . . . 2.5 mg.
(Warning: may be habit-forming)
Atropine sulfate . . . . . 0.025 mg.

Saves the Day

Warnings: Lomotil should be used with caution in patients taking barbiturates and, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions: Lomotil is classified as a Schedule V substance by Federal Law with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages



should not be exceeded, and medication should be kept out of reach of children. Signs of accidental overdosage may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is necessary. The subtherapeutic amount of atropine sulfate is added to discourage deliberate overdosage.

Adverse Reactions: Side effects reported with Lomotil therapy include nausea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant urticaria, lethargy, anorexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise.

Overdosage: The medication should be kept out of reach of children since accidental overdosage may cause severe, even fatal, respiratory depression.

Dosage: The recommended average initial daily dosages, given in divided doses until diarrhea is controlled, are as follows:

Children:

3-6 mo....½ tsp.* t.i.d. (3 mg.)
6-12 mo...½ tsp. q.i.d. (4 mg.)
1-2 yr.....½ tsp. 5 times daily (5 mg.)
2-5 yr.....1 tsp. t.i.d. (6 mg.)
5-8 yr.....1 tsp. q.i.d. (8 mg.)
8-12 yr....1 tsp. 5 times daily (10 mg.)
Adults:....2 tsp. 5 times daily (20 mg.)
or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful.

Use of Lomotil is not recommended in infants less than 3 months of age.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

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For more detailed medical information write.
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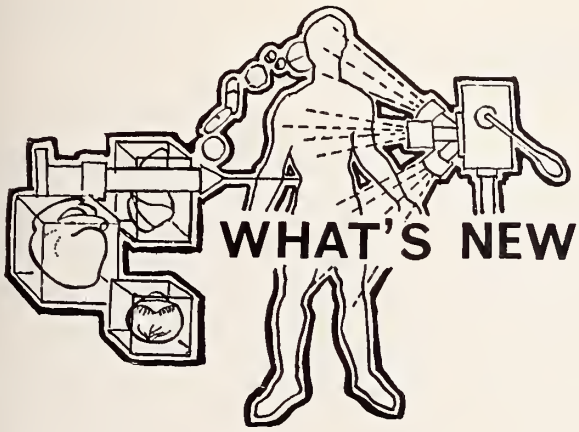


Additional information available to the profession on request.

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101488



WHAT'S NEW?

Avionics Research Products announces their Model 2600 METRETEL ECG Telemetry System. The patient wears a battery powered transmitter which weighs only two ounces. It may be worn in surgery, in recovery or in coronary care units, as well as during exercise tests such as Master's 2-step, stationary bicycle or treadmill. A remotely located receiver records the cardiogram.

* * *

Lilly announces Capastat[R] Sulfate (capreomycin sulfate, Lilly), an intramusclar antibiotic for the treatment of tuberculosis. It is recommended for use against susceptible strains of the bacillus in conjunction with other appropriate antituberculous agents. It is especially useful if other agents are toxic or ineffective. Capastat Sulfate carries the risk of renal and eighth nerve injury.

* * *

Now available—a low-cost compact kit called Mor-tek U which will quickly identify the morphine or heroin user by means of a urine test. Reliable results are obtained within 10 minutes from the time the urine specimen is taken. The kits are packaged for either individual use or mass testing. Each kit contains complete instructions and all components necessary.

* * *

Artek Systems is introducing the first high speed Colony Counter. The instrument can scan a standard 100mm petri dish having up to 1000 surface and sub-surface bacterial colonies, count and display count results within one-half second. It can perceive and tabulate colonies as small as .2 millimeters in size.

* * *

The Pall Corporation is expanding its line of blood filters. Two new units, suitable for filtering out microemboli generated during cardiopulmonary bypass procedures and the removal of minute particles from transfused blood, are available with either ⅜″ or ¼″ tubing connections. Luer fittings are also supplied.

* * *

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments, and surgical appliances and book publishers. Each item is published as news and does not necessarily constitute an indorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.



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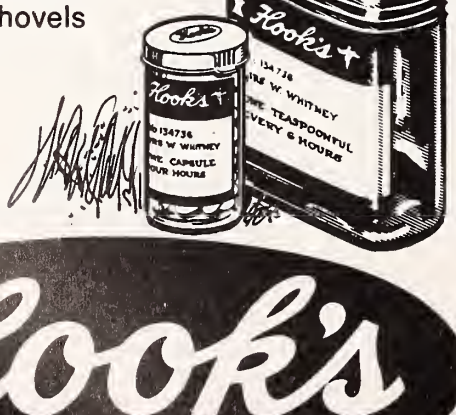
by the groceries and past the men's room

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Apparently a lot of people think real drug stores should sell drugs, not snow shovels



Hook's

DEPENDABLE DRUG STORES

What's New?

Smith Kline & French announces a new line of widely prescribed pharmaceuticals now being introduced under the uniform designation of "SK-LINE." Each product will be a high volume, standard pharmaceutical prepared with high quality, promoted as a line, and priced on the average 25% below the leading brand names. All product names will begin with the SK prefix, e.g. 'SK-Ampicillin.' Eight products will constitute the line originally—ampicillin, acetaminophen, meprobamate, esterified estrogens, penicillin VK, pentaerythritol tetranitrate, sulfisoxazole and tetracycline.

* * *

Mead Johnson announces plans to market MEGACE (Megestrol Acetate) for the adjunctive or palliative treatment of advanced endometrial cancer. It is said to be the first orally effective product to be marketed for this purpose. It will be marketed in light blue, scored tablets containing 20 mg of megestrol acetate in bottles of 100 tablets.

* * *

General Electric has a new full-color, 24-page publication to help hospitals in selecting electronic equipment which will match the needs in coronary care, intensive care, etc. The GE monitoring equipment is modular in form and can be fitted together in the right mix to accomplish exactly what each situation calls for. For publication #4296 write General Electric, 4855 Electric Ave., Milwaukee 53201.

* * *

Technicon Corporation has a fully automated antibody screening system which performs pre-transfusion testing with a high degree of accuracy. It detects clinically significant antibodies with a sensitivity equal to or superior to that of manual methods and does so at the rate of 30 samples per hour. The cost per test is about 25% of that associated with manual methods.

* * *

Eli Lilly announces that Keflex^{R} is now available for administration to young children. The recommended daily dosage for children is 25 to 50 mg per Kg, divided into four doses. The drug is dispensed in powder form—to be reconstituted by adding water—after which it may be kept in a refrigerator for 14 days without loss of potency. A dropper, calibrated at 25 and 50 mg, is supplied. The drops have a bubble-gum flavor.

* * *

Eli Lilly announces a new salt of Darvon—Darvon-N^{TM} (propoxyphene napsylate). The napsylate salt is insoluble in water and allows more stable liquid dosage forms and tablet formations with aspirin. Darvon-N is supplied in 100 mg tablets and in 100 mg tablets combined with 325 mg of aspirin.

Deaths

Paul C. Burnett, M.D.

Dr. Paul C. Burnett, 65, Logansport, director of the tuberculosis ward at the Logansport State Hospital, died Nov. 8.

A Fellow of the College of Chest Physicians, Dr. Burnett received his medical degree from the Tulane University School of Medicine in 1931 and had been on the staff at Longcliff since 1955.

He was a member of the Cass County Medical Society.

Joseph Markle, M.D.

Dr. Joseph Markle, Hobart, died Oct. 27.

A practicing physician in Hobart for the past 26 years, Dr. Markle was a 1939 graduate of Temple University Medical School in Philadelphia, a veteran of World War II, and a member of the Lake County Medical Society.

James S. McBride, M.D.

Dr. James S. McBride, 78, Indianapolis physician, died in Community Hospital, Springfield, Ohio, Nov. 7.

A World War I veteran, he was a member of the staff at Methodist Hospital and taught at the Indiana University School of Medicine before retiring in 1969.

Dr. McBride was a graduate of the Indiana University School of Medicine and had practiced in Indianapolis, specializing in chest infections, since 1922. He was a member of the Marion County Medical Society and a Senior Member of the Indiana State Medical Association.

In 1961, he was named by Governor Matthew E. Welsh to the Commission on Special Institutions, and in 1966 Governor Roger D. Branigin appointed him to the advisory committee for the Indiana State Hospital for Chest Diseases.

Herbert M. Woollen, M.D.

Dr. Herbert M. Woollen, 95, died October 19 in Methodist Hospital, Indianapolis.

President of the American United Life Insurance Company from 1912 until his retirement in 1940, Dr. Woollen had practiced in Indianapolis, specializing in diseases of the ear, nose and throat, from 1904 to 1910, and lectured at the Bobbs Clinic and the Department of Bacteriology of the old Indiana Medical College. He was graduated from the medical college in 1903.

A former member of the Marion County Medical Society, he was a member of the 50 Year Club of the Indiana State Medical Association.

David E. Wynegar, M.D.

Dr. David E. Wynegar, assistant medical superintendent at the Richmond State Hospital, died in October after an illness of three weeks. He also was in charge of the alcoholic rehabilitation program at the hospital. He was 71.

A graduate of the medical school of the University of Nebraska in 1928, he had practiced in Indiana since 1954, limiting his practice to neuro-spychiatry.

Dr. Wynegar was a member of the Wayne-Union County Medical Society. ◄

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—October 1971

Disease	Oct. 1971	Sept. 1971	Aug. 1971	Oct. 1970	Oct. 1969
Animal Bites	920	1236	1305	908	890
Chickenpox	174	20	24	109	191
Conjunctivitis	124	146	138	173	86
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	14	42	20	36	4
Gonorrhea	767	910	647	817	739
Impetigo	218	235	128	326	285
Infectious Hepatitis	43	60	37	42	70
Infectious Mononucleosis	109	85	34	117	89
Influenza	1391	584	279	1176	870
Measles					
Rubeola	15	18	20	1	3
Rubella	40	72	51	70	75
Meningococcic Meningitis	4	1	1	1	6
Meningitis, Other	1	4	3	3	7
Mumps	92	37	57	117	127
Pertussis (Whooping Cough)	0	6	3	23	7
Pneumonia	262	209	158	379	230
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	662	639	539	715	564
Syphilis					
Primary & Secondary	27	28	20	36	38
All Other Syphilis	83	120	100	139	97
Tinea Capitis	0	4	1	6	16
Tuberculosis (Active)	61	74	47	102	70

County, District News

Dearborn-Ohio

Dr. Merritt O. Alcorn, Madison, chairman of the Indiana Board of Medical Registration and Examination, was the speaker at the November meeting of the Dearborn-Ohio County Medical Society.

A committee was appointed to study the possibility of a public relations program relative to such things as emergency room service and securing the services of a physician.

Greene (Corrected)

The Greene County Medical Society met September 9 with 15 members present.

A Mr. Collins of Blue Cross Hospital Service explained Medicare relative to hospital stays.

It was announced that the 1972 meeting of the Second District would be held May 18 in Linton.

During the business meeting concern was expressed with regard to the Willkie "physician transplant" program, and Dr. Joe Dukes, ISMA board chairman, who was present, was instructed to urge that the Willkie group devote considerable effort to convincing Indiana medical graduates to practice in Indiana.

Fountain-Warren

Mr. Herbert Dixon, Blue Shield vice president, gave a report on Blue Shield matters and answered questions of the physicians present at the November 4 meeting of the Fountain-Warren County Medical Society.

The new president of the Indiana State Medical Association, Dr. Peter R. Petrich, Attica, attended the meeting.

Jefferson-Switzerland (Corrected)

Twenty-two members of the Jefferson-Switzerland County Medical Society were present for the September meeting of the group at Madison.

Knox

Dr. Roger Secker-Walker, of the Mallinckrodt Institute of Radiology at Washington University, St. Louis, gave a talk on Nuclear Medicine—Scanning at the October meeting of the Knox County Medical Society. Twenty-five members were present.

LaPorte

Dr. Alvaro Moreira, medical director of the Michigan City Mental Health Center, was the speaker at the October meeting of the LaPorte County Medical Society. His subject was Management of Drug Abuse Problems in the Emergency Room.

A film titled "What Did You Take" was shown.

New officers elected at a meeting of the board of directors on November 2 are: Dr. Clem H. Elshout, LaPorte, president; Dr. John W. Luce, Michigan City, vice president; Dr. James R. Carpentier, LaPorte, secretary-treasurer.

Dr. Fred S. Carter and Dr. Barbara Backer will serve as delegate and alternate from LaPorte, while Drs. John W. Luce and Peter J. Pilecki will be the Michigan City delegate and alternate in the coming year.

Named to the Judicial Council were Drs. Raymond J. O'Brien and Charles K. Liddell, Michigan City, and James J. Sprecher, LaPorte. At-large members of the Board of Directors will be Drs. John C. Richter and Florian Predd, LaPorte, and Drs. Frank McGue and Frank Kubik, Michigan City.

Marshall

A lecture on Hemorrhagic Shock was given by Dr. J. B. Collins, head of the department of anesthesiology, Cook County Hospital, Chicago, at the October meeting of the Marshall County Medical Society. Nineteen members were in attendance and participated in the discussion which followed Dr. Collins' talk.

Tippecanoe

Fifty members were present for the November meeting of the Tippecanoe County Medical Society at the Wabash Center for Mentally Retarded Children.

New officers elected were: Dr. John T. Burns, president; Dr. R. E. Hannemann, vice president; Dr. Caroline Hass, secretary; and Dr. David Evans, treasurer.

Wayne-Union

The October meeting of the Wayne-Union County Medical Society was held at the Richmond State Hospital.

Dr. Jefferson Klepfer discussed admission procedures and the various types of commitment at the hospital, Dr. Robert Anderson spoke of organization and treatment policies, and Miss Anne Withers discussed releases and family placement of patients by the social service department.

Twenty-six members and seven guests were present.

Wells

Ken Musser, prosecuting attorney of Wells County, was the speaker at the October meeting of the Wells County Medical Society. His subject was Legal Aspects of Medicine.

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Association News

BOARD OF TRUSTEES

August 22, 1971

The Board of Trustees of the Indiana State Medical Association convened in the Headquarters Building on Sunday, August 22, 1971. The meeting was called to order at 8:30 a.m. by the Chairman, Dr. Joe Dukes.

District	Trustee	
1	Gilbert Wilhelmus	Absent
2	Joe Dukes	Present
3	Eli Goodman	Present
4	Robert M. Reid	Present
5	Wilbert McIntosh	Present
6	Stephen D. Smith	Absent
7	James H. Gosman	Present
	Dwight W. Schuster	Absent
8	Richard G. Ingram	Absent
9	William M. Sholty	Present
10	Vincent J. Santare	Present
11	Lowell J. Hillis	Present
12	William R. Clark	Present
13	Otis R. Bowen	Present

Alternate Trustee

1	Raymond Newnum	Absent
2	Betty Dukes	Absent
3	E. L. Wallace	Absent
4	Jack E. Shields	Present
5	C. M. Schauwecker	Present
6	Paul M. Inlow	Present
7	John O. Butler	Present
	Joseph C. Kerlin	Absent
8	Robert D. William	Absent
9	Lindley H. Wagner	Absent
10	Thos. C. Tyrrell	Present
11	James A. Harshman	Present
12	Walter D. Griest	Absent
13	G. Beach Gattman	Present
	Max Hoffman	Present
	Thos. Neathamer	Present

Officers:

Malcolm O. Scamahorn, President	Present
Peter R. Petrich, President-Elect	Present
Lester H. Hoyt, Treasurer	Present
Hugh K. Thatcher, Jr., Assistant Treasurer	Present
Frank B. Ramsey, Editor, *The Journal*	Present

Executive Committee:

Donald M. Kerr,	Present
Wilbert McIntosh	Present

Delegates and Alternate Delegates to the AMA:

Don E. Wood	Present
Eugene F. Senseny	Absent
Frank H. Green	Absent
John S. Farquhar	Absent
Jack Shields	Present
James Harshman	Present
Eugene S. Rifner	Absent
Kenneth O. Neumann	Present
P. J. V. Corcoran	Absent
Thos. C. Tyrrell	Present

Guests:

Andrew C. Offutt, Secretary, Indiana State Board of Health	Present
Steven C. Beering, I.U. School of Medicine	Present
Joseph M. Black, Chairman Blue Shield Board	Present

Staff:

Robert J. Amick, field secretary	Present
Howard Grindstaff, field secretary	Present
John L. Walters, field secretary	Present
Kenneth W. Bush, administrative assistant	Present
Jas. A. Waggener, executive secretary	Present

Minutes of Meeting June 13, 1971

The minutes of the meeting held June 13, 1971 were approved on motion of Drs. Gosman and Clark.

Report of the President-Elect

Commission and Committee Recommendations

Dr. Petrich, President-Elect, reported to the Board and requested the cooperation of the trustees in obtaining names of members who would be willing to work on the various commissions in order that he might have a meeting with these individuals prior to the beginning of his term and have a full year's work planned for the various commissions and committees.

1976 AMA Meeting and New Orleans Party

Dr. Petrich also requested permission of the Board for the delegation to the AMA to seek the 1976 Clinical meeting to be held in Indianapolis rather than in Philadelphia. As a means of promoting this idea, Dr. Petrich suggested that, rather than operating a hospitality room as in the past, the hospitality suite activities be curtailed somewhat and in place of that the association put on a grand party on one night during the meeting, at which time all of the AMA delegates would be invited.

Dr. Gosman Motion

Dr. Gosman moved acceptance of the recommendation of Dr. Petrich and the Chairman requested a division of the question, first asking for a motion on requesting the AMA to move the 1976 meeting from Philadelphia to Indianapolis. The motion was made by Dr. Gosman, seconded by Dr. McIntosh, put to vote and carried. The second part of the question regarding the party in New Orleans was discussed by several. Dr. Gosman moved that we hold such a party. The motion was seconded by Dr. Santare. The motion was further discussed by the Chairman, Dr. Hillis and Dr. Gosman.

DR. GOSMAN: I have discussed my motion with Dr. Santare and I have permission to amend the motion. I would then amend the motion to read that the Board look favorably on the motion made by Dr. Petrich to hold a grand party in New Orleans and that he investigate this further as to cost and expenses and report back to us by whatever means he wishes. The motion was then put to vote and carried.

Model Practices Act

Dr. Petrich requested that permission be granted through Board action to send the Commission on Medical Education and Licensure, for their study and final decision to possibly three, four or five areas of the state (much as was done with the Ad Hoc Committee to Blue Shield) regarding a model Medical Practices Act.

Dr. Gosman Motion

Dr. Gosman moved acceptance of the suggestion of the president-elect, seconded by Dr. Reid. The motion was further discussed and the suggestion was made that it also be referred to the Board Committee which had previously worked on this and that Dr. Gosman amend the motion to include the Board Committee along with the Commission on Medical Education and Licensure. The motion was amended, put to vote and carried.

County Society Officers Meeting Nov. 3-14

Dr. Petrich next requested that the Board endorse an idea he had for the week-end that normally has been called the County Society Officers Meeting, stating he would propose that the Board, the officers of component county societies and the delegates to the House of Delegates be invited to a Saturday and Sunday meeting in Indianapolis in early November of this year for the purpose of education in the field of computer medicine. He felt it is important to devote a meeting to this subject, as he believes we have failed to do the job of providing education to our members regarding the role of computers in the practice of medicine.

DR. PETRICH: I would propose an exhibitor type of program in the afternoon on Saturday, the AMA delegates meeting with the Board on Saturday evening, and continuing on Sunday morning with a formal presentation regarding the role of computers.

Dr. Gosman motion

Dr. Gosman moved the acceptance of the recommendation of Dr. Petrich, seconded by Dr. Reid, put to vote and carried.

Report of Executive Secretary to Board

DR. PETRICH: Finally, I would like to propose to you that an overlooked source of information be made a regular part of our agenda. The officers of the association report regularly to the Board of Trustees, as you know, and it is my opinion that the executive secretary, who has a great deal of information, could be helpful to us by reporting in a regular slot every time that the Board meets.

Dr. Gosman motion

I would move the acceptance of the recommendation of Dr. Petrich that the executive secretary make a report to this Board if he has any matters to report. The motion was seconded by Dr. Goodman, put to vote and carried.

Report of the Treasurer

Dr. Hoyt, the treasurer, reviewed the Statement of Financial Condition; the Statement of Income and Expenses; Schedule of Cash and Short Term Treasury Bills; Schedule of Long Term Investments; Scheduled Expenses of Committees, Commissions, Officers, Board Meetings; Headquarters Office Expense; Journal Fund Expense; Building Fund and the Statement of Financial Condition of the Student Loan Account.

Dr. Hoyt commented that this is a new format our new bookkeeper has worked out, a combination made possible by our having a computer service available and a good bookkeeper. Dr. Hoyt moved acceptance of his report, seconded by Doctor Petrich, put to vote and carried.

Report of the President

AMA Communications Institute, Chicago

DR. SCAMAHORN: I have nothing particular to say other than to make a brief report on the recent Communications Institute held by the AMA. Jerry Pettis, a congressman from the State of California, a member of the House Ways and Means Committee, talked about National Health Insurance. He complimented the AMA for taking a positive approach to this question, pointing out that during the 91st session of the Congress, the AMA had testified 34 times and of that, 32 times was positive in their testimony. He reported that Congressman Rogers, a Democrat from Florida, stated that the AMA was the only health organization that testified in favor of the Manpower Bill as written, pointing out that neither Mr. Kennedy or the Department of HEW appeared to give testimony on this subject. Mr. Pettis reported that one of the first matters the House Committee would consider upon their return to Washington would be the matter of the economy and the price freeze. Inasmuch as the Congress has set an adjournment date no later than November 1, he pointed out that the committee would probably not have any hearings this year on any of the health insurance proposals. He stated that perhaps in the spring they would have some hearings on these various proposals. From private talks with other members of the Ways and Means Committee, as it is presently composed, he thinks they will not buy the Kennedy proposal. He further predicted that the Kennedy Bill would not even come out of committee. He suggested that we be ready and look for a fight in the next presidential election coming up next fall, as National Health Insurance will probably be one of the major issues.

Dr. Wesley Hall to Attend ISMA Convention

I have received an acceptance from the President of the AMA, Dr. Wesley Hall, to attend our annual meeting. As yet we have not had an acceptance from a speaker for the President's Luncheon. This is my report, Mr. Chairman.

CHAIRMAN: We will now ask Dr. Ramsey, Editor of *The Journal* to make his report.

Report of the Editor

May Issue of Journal

DR. RAMSEY: I would like to report that our May issue which was devoted to the Drug Problem has already attracted some national recognition. We have received requests for copies from the Deputy Attorney General of New York City; the Mental Health Association of Florida; a Professor of Chemistry in Georgia; and several from surrounding states, such as Michigan and Wisconsin.

Reprints for High Schools on Request

We have had the drug articles reprinted, of which you have a copy, and as soon as schools open this fall, one of these will be mailed to each of the High Schools and Junior High Schools in the state. The Commission on Special Activities has also requested that, should a heavy demand for these reprints develop this fall, we should make arrangements for reproducing them in quantity and distributing them at no cost to schools and other organizations.

Report of AMA Trustee

CHAIRMAN: Thank you, Dr. Ramsey. Now I would like to ask Dr. Wood, newly elected Trustee of the AMA, to make some remarks.

DR. WOOD: Thank you, Mr. Chairman and members of the Board, for the opportunity of letting me express to you my thanks for the effort which was put forth at the AMA meeting which resulted in my being elected to the Board of Trustees. With that goes a great responsibility and I am sure that with it goes your best wishes for my being able to fulfill this responsibility. In the meantime, my principal assignment from the Board is to be the liaison contact with the Woman's Auxiliary of the AMA. I think this is a good freshman assignment myself. I will always try to share with you any information that will be of importance to this organization and will make all the meetings.

The second item I would like to bring to you is that being on the Board, full time is needed to fulfill the responsibilities of this office and it is the policy of the Board that you do not hold two offices in the organization, so with that knowledge, I hereby submit my resignation as a delegate to the AMA from the ISMA at this time. Thank you very much.

The resignation of Dr. Wood was reluctantly acepted on motion of Dr. Gosman and Dr. Scamahorn.

Dates for District Meetings

CHAIRMAN: We will now move to item 4, page 26; dates for the district meetings.

1st District—No report

2nd District—Unable to report date at this time

3rd District—April 5, Marriott Motel, Clarksville

4th District—May 17, Madison

5th District—May 24, Terre Haute

6th District—May 3, Shelbyville

7th District—June 14

8th District—June 7

9th District—June 28, Lebanon

10th District—Date has not been set

11th District—September 15, 1971 and '72 date will be set at that time

12th District—September 1972, date has not been set

13th District—September 8, 1971 and '72 date will be set at that time.

Remission of Dues

DR. DUKES: Dr. Dukes reported he had received a request for the remission of dues for Dr. Philip T. Holland of Bloomington who is ill and not in practice. The request was granted on motion of Dr. Petrich and Dr. Bowen.

Introduction of New Trustee

DR. GOODMAN: I would like to introduce at this time Dr. Thomas Neathamer of Jeffersonville, the alternate trustee-elect for the 3rd District.

DR. SHOLTY: I would like to introduce at this time Dr. Max Hoffman of Covington, the alternate trustee-elect from the 9th District.

Matters Referred by Executive Committee

Medical Practice Act

DR. KERR: There are three major items which the Executive Committee is referring to the Board. The first is one to which Dr. Petrich has already referred relative to the Medical Practice Act; the Medical Disciplinary Act and the Sick Doctor Statute. Incidentally, we know there are three vacancies at this time on the Board of Medical Registration and the president and the executive secretary are instructed to check with the Governor to see if something can be done not only to fill the vacancies but to fill them with people of some strength.

Autopsies

The second item is that we have a letter from Dr. William Province of Franklin, who is writing as Chief of Staff of the Masonic Home Hospital, Franklin, concerning what he believes is undue pressure on the part of the Board of Health for them to perform additional autopsies in this hospital. Inasmuch as Dr. Offutt is here, I think he would like the opportunity to say a few words about this matter.

DR. OFFUTT: When we first took over Silver Crest Hospital, I found there was apparently the same kind of thing going on—we were trying to do a lot of autopsies and bragging about the fact that we were getting autopsies on about 80% of the deaths. I personally felt that everyone who had been admitted to this hospital was diagnosed as a tuberculosis patient and died of that disease and that we were not going to learn a lot by autopsies that we did not already know before death occurred. I predict that by the next meeting you will find that we have taken care of the question with the Masonic Home Hospital.

Dr. Offutt went ahead to comment on some of the problems they had in nursing homes, pointing out it is not the State Board of Health asking for the records but the Federal government is asking the State Board of Health to ask for the records and there is not a thing that he, as Commissioner of the State of Indiana, can do about this. He stated there is not a day goes by but what he wishes there was something he could do about the problem.

IRMP Questionnaire

DR. KERR: The third item is a letter from Indiana Regional Medical Planning addressed to the state association. The letter seeks approval of the state association and the cooperation of the association with the Cancer Committee of IRMP regarding a questionnaire which they propose to send to administrators of general hospitals throughout the state. They seek our endorsement of the use of the questionnaire. In the material submitted provision is made for the medical men of the hospital concerned to answer the medical questions and the administrative and inventory questions can be answered by hospital administrators. It further points out that the results of the survey would be available to the association when completed.

The Executive Committee felt it was not a bad thing. The motion was made to approve the questionnaire, duly seconded, put to vote and carried.

Review Mechanism State Welfare Dept.

DR. PETRICH: One item which the executive secretary reported to the Committee at our meeting last night was that he had been approached concerning the possibility of the State Welfare Department making a recommendation that the Indiana State Medical Association handle the peer review and utilization review of the welfare programs in the State of Indiana. We felt this should be referred to the Commission on Governmental Medical Services for them to meet with the Welfare officials and find out what they had in mind and to come back to us with a report. So if you ever hear of a report about review mechanism in government medicine you will know what it is all about.

Report of AMA Delegates

CHAIRMAN: Since the delegates are not present as yet, we will skip their reports and move on to reports of our guests.

Reports of Guests

Sickle Cell Anemia

DR. OFFUTT: Thank you, Mr. Chairman. I would first like to discuss the matter of testing for sickle cell anemia. As you know, the last legislature included this test in our present Act. I have already had a letter suggesting that we make this compulsory for school entry. My reply is "no"; I think it is unnecessary. Apparently there was a lot of confusion among doctors, from the calls and letters I received. The bill just simply states you will say whether or not the child has had a test for sickle cell anemia and it does not say any more than this.

Hospital Expansion And Construction

The next item I would like to discuss is that we have had some problems in three areas of Indiana with hospital expansion and construction. The problem has been, in the three instances, that it has been said that the State Board of Health will not permit additional beds to be built onto a hospital or a hospital to be built and what is actually being said is (1) that Blue Cross will not consider any change in rates based on capital expenditures in a hospital in which the area-wide planning agency has not reviewed it. My attitude, and the attitude of the Board of Health is that it is quite true that the area-wide planning agency should undoubtedly review new hospital planning or any nursing home planning or any other health facility planning. I do not know how to make it any simpler. The only way a hospital or community can beat this requirement is to either sue them or have a law passed similar to the one introduced in this session of the legislature to provide for the State Board of Health to issue a certificate of need. I find we can do this already but only in those cases where the hospital is seeking an FHA loan. I understand from some of the discussion in the last session of the legislature that the bill, as introduced, did not protect some individual or a group of individuals who desired to build a hospital on their own with their own funds. I do not see any reason why this could not be written into the law along with any other protective device which is needed. It is rather unusual in this state in which the insurance carrier can control the supply of beds in the area.

Nursing Homes

The third matter is that I am quite concerned with respect to the flowing away from the Board of Health to other groups

of the health functions of this state.

Dr. Offutt was asked to discuss the requirements which are foisted upon the Board of Health and, in turn, upon the nursing homes which mandates visits of physicians and progress notes on strictly domiciliary beds.

DR. OFFUTT: In 1957 we took over the matter of nursing home licensure and we found the situation deplorable. People went into nursing homes with all types of agitated depression—they were just old people and there was nothing seriously wrong with them except age. A study of nursing homes and the conditions therein at that time would actually make you ill. Our state at that time was full of what we call "human kennels," and I am not being unkind when I use this term. Some years ago the Federal government passed an Act which said, in essence, that any nursing home in operation would have to have a licensed operator. Then Indiana passed such a law. At a meeting in Washington I made the discovery that the Federal government, through the use of Medicare and Medicaid, established a program which, in essence, was that nobody can inspect a nursing home who has not been brainwashed by the Federal government. The interesting thing is that not even the State of Indiana could do this, but we were providing people to teach in this course of study and obviously we did not have anybody on the staff who knew how to inspect a nursing home.

Now the thing you are talking about here today is going to become a reality because I have had the privilege of seeing a proposal which has gone so far as to be typed and it is to be placed in the Society Security requirements to require a physician to see a patient in a nursing home every 30 days or more often.

QUESTION: I realize you are not reporting on the Welfare Department, but is there any thing in the rules that you know of to get some of the people now being care for by Medicaid certified as intermediate care patients who really do not need hospital care so they could be transferred to domiciliary care?

DR. OFFUTT: Yes, the matter is under considerable study right now.

CHAIRMAN: Thank you, Dr. Offutt. We will now move on to Dr. Beering for a report from the dean of the I.U. School of Medicine.

Report from Dean Irwin

DR. BEERING: Thank you, Dr. Dukes. I do bring greetings to the Board from Dean Irwin, who regrets he was unable to be with you today.

I have been asked to do several things, one of which is to do a follow up report on the state-wide plan for medical education. Let me start with an overview and a status report of this exciting program and tell you about the two phases that are now extant in the continuing and postgraduate phase and then the undergraduate phase. The program goes back to '67 which was funded by the General Assembly to help maintain a continuing and postgraduate medical education program for interns and residents and practicing physicians.

This year Part A was funded for $875,000, which provides a $2500 stipend for interns and residents at community hospitals under the supervision of the Medical Education Board. It also provides for the interns at the university hospitals but not for the residents.

Part B was funded this year at $1,200,000. It provides for salary supplements to directors of medical education at community hospitals, the audio-visual communication system, including TV, library and phone services, programs for visiting professors, and individual medical education grants in aid to community hospitals.

We are happy to tell you that this program, which is now four years old, and has spent the sum total of $5½ million has resulted in an increase from 428 to 608 interns and residents; 181 physicians in training, which is a 42% increase in four year's time. This is a result which is unmatched in any state by any medical school and no one else has done it in this space of time for this little money.

As you all know, the Indiana General Assembly, following the recommendation of the Governor's Commission and your very generous support, approved unanimously and partially funded in April of this year House Act 1430, which provides for the establishment of a center for medical education in conjunction with the universities of the state in the communities of Lafayette, South Bend, Muncie, Evansville, Gary, Fort Wayne and Terre Haute. The General Assembly funded $1¾ million and we were fortunate in attracting another $1.6 million from Federal sources, making the program a reality this year. With these two programs side by side, we were able to increase our enrollment for this fall class to 273 incoming freshmen, 23 more than we had last year.

I would quickly like to review some events of the last several months which I think are exciting and which we need to share with you. In January of this year the Carnegie Commission on Higher Education cited the Indiana statewide program as an example and as a prototype for the area health education centers which it recommended nation-wide. In February the Governor's Commission on Higher Education passed a resolution vesting the responsibility and authority for this expansion program in the School of Medicine. In March we appointed the first three directors. In April the General Assembly passed and the Governor signed into law House Bill 1430 creating these regional centers.

In May we struggled with the appointment of additional directors, identifying faculty, looking at curriculum, looking at space for these centers and made preliminary determination as to which centers would have first year students. We decided that all centers would have senior students this year as a part of their senior elective program. I might mention that last year 60% of our senior class was assigned to 34 community hospitals and 56 individual physician preceptors, with 60% of the entire senior class off campus. This experience will be repeated this year.

We have, as of this date, accomplished completion of affiliate agreements from all of the universities of the state, both public and private, and with most of the hospitals. The fact is there are probably 14 hospitals that may call themselves university affiliated. Also in April we had the inspectors from the Joint Commission on Accreditation and they went over every regional facility as well as the university at Indianapolis and Bloomington with a fine-tooth comb. I called to find out how we were getting along with the results of their inspection and while the vote from the members on the Accreditation Commission is not in, I obtained a preliminary view that we will be granted approval for the school and state-wide plan.

In June we learned that the physician-augmented grant, which we received last year, enabling us to extend the pilot phase, was re-approved and refunded and that is how we got the other $1.6 million to carry on the program.

This coming Tuesday we will enroll 273 students. They will have freshman orientation exercises in Indianapolis, then have a day's travel and attitudinal readjustment and show up at the various centers, and we will then be in business. We will have six different locations this fall for freshmen medical school instruction. The Bloomington school also has second year medical students for a total of 125 students off the Indianapolis campus in the basic medical sciences.

There will be over 140 seniors at any one time off campus as well, so we are off and running and, as I told you a previous time, one of the problems now is

that everyone is copying us and are spending significant portions of time every week telling people how we are doing it. We have had to limit visiting delegations to one per week. You might be interested to know that the State of North Carolina has enacted and funded a program identical to ours.

A question was asked about the enrollment in the various centers.

DR. BEERING: There will be 200 freshmen in Indianapolis, there will be 33 at Bloomington, 8 at Terre Haute, 12 at Lafayette, 10 at South Bend and 10 at Muncie. In addition, as far as sophomores are concerned, there will be 30 sophomores in Bloomington and then a variable number of seniors at all these centers throughout the state.

QUESTION: What happened to Evansville?

DR. BEERING: There are no freshmen students at Evansville; however, there are some 30 seniors this year. The reason there are no freshmen at Evansville or Gary is that we were simply unable in the short space of time to get the physical facilities ready to conduct a program and also to get faculty and curriculum established. We are planning to have freshmen students at both these locations in the coming year.

QUESTION: I know that Dr. Richey heads up the Admissions Committee. Who are the other members of this committee?

DR. BEERING: I guess also what you are asking is how do people get assigned to the centers? Dr. Ritchey is Chairman of the Admissions Committee; Dr. Lukemeyer is the secretary. The committee consists of 30 doctors. I cannot give you individual names because I do not remember them all. As far as this new program is concerned, it should be of interest to you to know that the center directors are largely represented on this committee. To get in any phase of the system the students make application to the School of Medicine and are screened by the Admissions Committee which, as you know, takes into account their college records, both their science performance and general performance, and how they did on the medical college aptitude test. They also are subjected to two personal interviews. We are unique in that we do interview each and every applicant for medical school. Once the student has been granted admission, he is sent a letter which gives him an option. This year we said, "Dear Joe, you have been accepted to the I.U. School of Medicine. We will have programs this fall at six different places. These are all listed and include I.U.-Indianapolis; I.U.-Bloomington; and four other centers." It will surprise you that, of our first 200 applicants, we received word back that 93 students put their first or second choice off the Indianapolis campus so we had no problem at all filling the centers with the number of students we thought we could assign there.

The question was raised concerning problems of gaining admission to medical school.

DR. BEERING: Well let me tell you there were 1700 applicants this year and we have room for 273 students. The average performance on the MCAT was 60th percentile, which is fantastic. The average quality point performance was 3.4. It is a real heartbreak to tell students who, you felt, were excellent students that they cannot be accepted in the I.U. School for this year. Uunfortunately, we just cannot take them all. Nationally, the number of students who get acceptance is about one out of two and the fact that we have a lot of applications represents to us that we have a wonderful medical school. I might say that out of that 1700 there were only about 500 from Indiana. You do need to recognize that well over 90% of all our students are Hoosiers. We do give preference to in-state students.

Dr. Beering went on to discuss the Department of Family Practice, which will be headed up by Dr. Alan Fischer and eventually they will have a full time Department of Family Practice and a Family Practice Residency. In concluding the discussion, Dr. Beering talked about the preceptor program as a senior elective, reporting that it is a very popular program, stating that approximately 60 senior students had availed themselves of the opportunity to take a preceptorship under a practicing physician.

CHAIRMAN: Thank you, Dr. Beering. We will now call on Dr. Black, Chairman of the Board of Blue Shield.

ISMA Board Meeting and Lunch

DR. JOE BLACK: I am happy to announce that Blue Shield is in the process of moving into its new offices. We hope to be in the building by the middle of October and we are extending to you at this time an invitation to have lunch during your October meeting and, if you would like to have a Board meeting in our new building, we would welcome you to have lunch and meet there at that time. I hope you can see fit to work this invitation into your busy schedule during the state meeting. We would look forward to having you with us in October to show you our new facilities and I would hope that most of Blue Shield will be moved under one roof by that time.

Blue Shield Directors Retreat

In July we had our first Directors' Retreat for Blue Shield in which I attempted to make your directors better informed about the insurance business and develop a better understanding of our fiscal and actuarial problems and our claims. We had 80% of the Board there and I think all who attended were very appreciative of the program. Most recommended that we repeat this again in the future. While I am talking about directors, I have discussed with the Commission on Constitution and Bylaws of the Indiana State Medical Association the question of tenure of the Blue Shield Board members. As a result of this meeting, I believe they better understand our problem and I understand will present to the House of Delegates a change in the Constitution removing the limitation to two terms as a member of the Blue Shield Board. I would hope that the Board of Trustees would approve this matter.

Blue Shield Board Members

Doctor Black concluded with the recommendation that the association might look to its Commission on Medical Economics and Insurance and Governmental Medical Services as its source for members for the Board of Blue Shield. He also informed the Board that he was impressed with the film clips which had been prepared by the AMA and felt there was a good possibility they could assist the association in sponsoring these materials in the communications industry.

Simplification of forms

Doctor Black's report was discussed and a question raised concerning the simplification of forms for indicating the need for a second visit or additional visits to patients in nursing homes. Dr. Black indicated that a simplified form could be prepared. Also, some dissatisfaction was expressed concerning the method of processing claims for nursing home visits.

CHAIRMAN: We will now call on Doctor Owsley, Chairman, Council on Medical Services.

Article in Saturday Review

DR. OWSLEY: I would call your attention to the article in *Saturday Review* which you have and it is probably one of the most excellent statements on health care proposals. I would urge you to read

it very thoroughly as I believe there is good information in it for you. Thank you.

Revision of Rules Grievance Com.

CHAIRMAN: We will now back up to item 6a, Revision of Rules and Procedures of Grievance Committee. On motion of Dr. Goodman and seconded by Dr. Petrich, the proposal of the Grievance Committee for revision of rules and procedures of the Grievance Committee was approved and the committee is to be commended for doing an excellent job on the revision.

CHAIRMAN: We will now move back to the report of the Ad Hoc Committee on Physician's Assistants.

Physicians Assistants

DR. PETRICH: The AMA has recently released two publications, one by the Council on Medical Services and one by the chairman of the Board of Trustees, both of which follow almost exclusively the ideas we have come up with in the course of our deliberations. Prior to the October meeting, my committee will meet to prepare its report for the Board of Trustees.

Board Committee on Streamlining State Meeting

DR. SANTARE: We had a meeting shortly before this meeting and we took the model of an association of which the meeting was begun on Sunday and all the business was transacted in two days, with the meeting lasting from Sunday to Wednesday. They had three meetings of the House of Delegates. On the final day they met at nine a.m. for the election of officers and it was accomplished in a couple of hours because they shortened up the nominating procedure. I think this is a good model to follow and we hope to be able to present this on a more satisfactory basis at the next meeting of the Board.

MR. WAGGENER: I would like to call your attention to a matter to which I believe you should give serious thought during the coming months. In past years we have almost entirely financed our annual meetings with income from our exhibits. We hit a peak of 125 exhibits a few years ago and this has been consistently dropping to the point where I have only arranged for 75 exhibits this year and it is doubtful that we will sell all of these spaces.

In checking with some of the surrounding states, I have found they have not filled their exhibits during their meetings this year. Recently in a meeting in Washington with secretaries from other states and with officials of the Pharmaceutical Manufacturers Association, I came away with the impression that the day of financing meetings through the sale of exhibit space is about to come to an end. I therefore believe that this association will have to consider other means of financing annual meetings than sale of exhibit space. Some states have dispensed with exhibits already and are currently charging a registration fee of their members for attendance at the meetings. If we break even on exhibit space this year, we will be lucky.

A question was asked of Mr. Waggener concerning the cost of the meeting. He pointed out that meetings cost between $20,000 and $25,000 and, in 1970, the income from exhibits was $13,250. As you are aware, there is a resolution before the House to dedicate $3 of annual dues strictly for the purpose of paying honorariums for speakers at our annual meeting.

Statistics on Meetings

DR. HOYT: I have some figures which might be of interest to the Board. In 1964 our exhibit income was $24,000; in 1965 it was $29,948; in '66 it was $12,000; in '67 it was $16,000; in '68 it was $16,900 and in 1970 it was $13,250.

Resolutions

CHAIRMAN: We will now move on to item 9; Resolutions which have been received for the 1971 annual meeting.

On motion duly made and seconded, the resolutions were received for information.

1975 Meeting

CHAIRMAN: We are to make recommendation to the House of Delegates for the 1975 meeting.

Motion

DR. GOSMAN: I move that Indianapolis be accepted for the 1975 meeting. The motion was seconded by Dr. Santare, put to vote and carried.

CHAIRMAN: Under the Constitution and Bylaws this Board is to recommend the location of annual meetings for five years in advance; therefore, we should also make a recommendation for the 1976 meeting.

Amended motion

DR. GOSMAN: I will amend my motion to make it Indianapolis in 1975 and 1976. The amended motion was seconded by Dr. Santare, put to vote and carried.

Next Meeting

CHAIRMAN: Our next regularly scheduled meeting will be October 11 at 12 noon in the cafeteria of the new Blue Cross-Blue Shield building, with the meeting continuing thereafter. We will now adjourn the meeting and go into Executive Session.

EXECUTIVE COMMITTEE

October 11, 1971

Roll call showed the following present: Donald M. Kerr, M.D., Chairman; Wilbert McIntosh, M.D., Malcolm O. Scamahorn, M.D., Peter R. Petrich, M.D., Joe Dukes, M.D., Lester H. Hoyt, M.D., Hugh K. Thatcher, Jr. M.D., Frank B. Ramsey, M.D., and James A. Waggener.

Guests: Gilbert M. Wilhelmus, M.D., William Clark, M.D., Irvin W. Wilkens, M.D., Harry E. Kitterman, M.D., Mr. Charles Edgar and Mr. Clarence Fox.

Minutes of the meeting held August 21 were approved on motion of Doctors Petrich and McIntosh.

Membership Report

The membership report as of September 30 was approved by consent.

Number of members as of December 31, 1970	4,505
1971 members as of September 30, 1971:	
Full dues paying members	3,962
Residents and interns	84
Senior	373
Board remitted	54
Honorary	3
Military	36
Total 1971 members as of September 30, 1971	4,512
Total 1970 members as of September 30, 1970	4,478
Number of AMA members as of December 31, 1970	4,337
Number of AMA members as of September 30, 1971	4,253
Full dues paying	3,707
Exempt, but active	546
	4,253
Number who paid state dues but not AMA dues as of September 30, 1971	259
Number who paid state dues but not AMA dues as of December 31, 1970	168

Headquarters Office

ADDITION OF COLLATOR—The secre-

tary requested permission to add a collator to the present Xerox equipment and he was authorized to do so on motion of Doctors Petrich and McIntosh.

EMPLOYEE RETIREMENT—The secretary explained that a previous communication indicated the association would have to revise its employee retirement plan by Jan. 1, 1972, but he has since been informed that, under the OEP Program, the Internal Revenue Service has reversed itself and no changes are necessary at this time.

AUTO LEASING—Mr. Edgar of the Ohio State Medical Association and Mr. Fox then discussed the possibility of arranging an auto leasing plan for members of the Indiana State Medical Association. This matter was to be further explored and definite quotations are to be requested from the leasing company.

Treasurer's Report

The Treasurer's report was approved on motion of Doctors Hoyt and Petrich.

Organization Matters

ILLINOIS LEGISLATION ON FEE SPLITTING—A letter from Illinois concerning the passage of a recent piece of legislation in that state prohibiting fee splitting was reviewed for the information of the committee.

CHIROPRACTOR ADDRESSES CLASS—A news item indicating a chiropractor had addressed a physical therapy class at the I.U. School of Medicine was read for the information of the committee.

LETTER FROM DR. OFFUTT—A letter from Dr. A. C. Offutt announced the fact that Dr. Malcolm O. Scamahorn had been appointed to fill the vacancy caused by the death of Dr. G. O. Larson on the Advisory Hospital and Health Facilities Planning Council.

LETTER FROM DR. SOPER—A letter from Dr. Soper addressed to Dr. Kintner and dealing with the proposed program of the Committee on Medicine and Religion was reveiwed and referred to the Board of Trustees.

MINUTES OF COMMISSION ON MEDICAL EDUCATION—The minutes of the Commission on Medical Education meeting held September 12 discussing the proposed meetings for discussion of a new Medical Practice Act and the matter of foreign medical graduates was reviewed for the information of the committee.

BULLETIN NORTH CAROLINA MEDICAL SOCIETY—A bulletin from the North Carolina Medical Society concerning their meeting with Blue Shield officials was reviewed for the information of the committee.

RENEWAL MEMBERSHIP INDIANA TRAFFIC SAFETY COUNCIL—A request for renewal of membership in the Indiana Traffic Safety Council was approved on motion of Dr. Petrich and taken by consent.

FIRST DEATH PAYMENT—The secretary reported that the first death claim in the amount of $10,000 under the association's program had been paid to the widow of Dr. George T. Paulissen.

CORRESPONDENCE DR. J. W. LOHMAN WITH HEW—Correspondence between Dr. J. W. Lohman of Wanatah with the Secretary of HEW was reviewed for the information of the committee.

BILL ON PHYSICIAN'S ASSISTANTS—A copy of a bill enacted by the state of Alabama on Physician's Assistants was reviewed for the information of the committee. This is to be referred to the Commission on Legislation for study.

BULLETIN FROM HEW—A bulletin from the Department of HEW concerning increase in cost to Medicare recipients was reviewed for the information of the committee.

WHITEHOUSE CONFERENCE ON AGING—A copy of a letter from Dr. George Davis, Executive Director of the Indiana Commission on the Aging and Aged, addressed to Dr. Arthur Fleming, White House Conference on Aging, concerning a physician being selected to serve as a delegate, was reviewed for the information of the committee.

LEGAL OPINION ON MEDICAL SOCIETY FOUNDATION—A legal opinion regarding a county medical society forming foundations was reviewed and, by consent, was referred to the Board of Trustees. The secretary was instructed to send copies of this to the president and secretary of county societies in the next mailing which was made to this group.

REQUEST FOR MAILING LIST INDIANA DEPT. OF COMMERCE—A request for use of the mailing list for the Indiana Department of Commerce to distribute a booklet on "Project Prosperity" was approved on motion of Drs. Petrich and Thatcher.

MEMO FROM COMMISSION ON SPECIAL ACTIVITIES—A memo from the Commission on Special Activities was referred to the Board of Trustees on motion of Drs. Petrich and Scamahorn.

Annual Convention

A report on the sale of exhibit space for the '71 meeting was given for the information of the committee.

The Journal

A revised copy of a suggested ad for Weight Watchers of Central and Northeastern Indiana was reviewed and the ad is not acceptable in its present form.

Legislation

A letter from the Indiana Nursing Home Association seeking cooperation of ISMA in opposing some of the legislation dealing with nursing homes was reviewed and, on motion of Drs. Petrich and McIntosh, the association is to forward a comment from the AMA to the Indiana Nursing Home Association adding their support to their request.

Welfare

COURT ACTION MEDICAL INFORMATION—Dr. Wilkens and Dr. Kitterman appeared before the committee to discuss the recent court action concerning divulging medical information in Welfare Department files and also a legal opinion on the court action from the association legal counsel. After a discussion, it was taken by consent to refer this to the Board of Trustees.

AUXILIARY OBSERVER PROGRAM—Dr. Kerr brought up the matter of members of the Auxiliary acting as observers for nursing homes on behalf of the State Board of Health and this matter was referred to the Board of Trustees.

Future Meetings

Attention was called to the meeting of the AMA Committee on Aspects of Automotive Safety in Washington, D.C., November 9-10 and no representative is to be sent.

There being no further business, the committee adjourned to meet again at the conclusion of the final meeting of the House of Delegates and the organizational meeting of the Board of Trustees.

EXECUTIVE COMMITTEE

October 14, 1971

The Executive Committee met at 6:30 p.m. in the Mecca Room of the Shrine Club for the purpose of reorganizing the committee for the coming year.

Dr. Gosman was welcomed as a member of the committee by virtue of his having been elected president-elect.

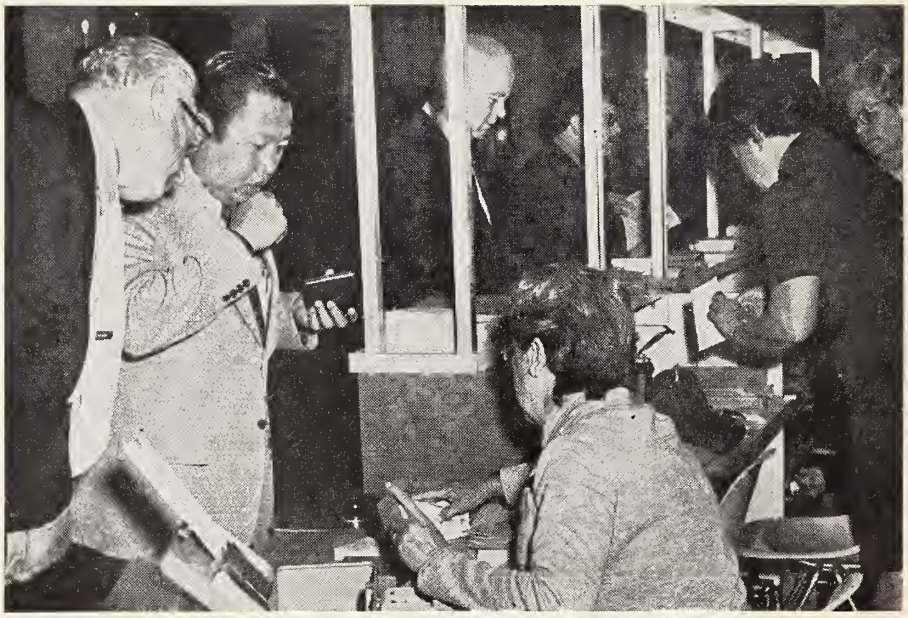
Roll call showed the following present: Donald M. Kerr, M.D., Wilbert McIntosh, M.D., Peter R. Petrich, M.D., James H. Gosman, M.D., Joseph Dukes, M.D., Lester H. Hoyt, M.D., Hugh K. Thatcher, Jr. M.D., and James A. Waggener.

By secret ballot, Donald M. Kerr, M.D., was elected chairman of the Executive Committee for the coming year.

There being no further business, the committee adjourned to meet again at 9:00 a.m., Saturday, November 13, in the Headquarters building. ◄

The Convention Story - 1971







Starts

at the

Registration

Desk



THE Executive Committee got off to an early start on Monday morning.



ISMA President Peter Petrich and Auxiliary President Mrs. Stanley Chernish.



FIFTY-YEAR club members and their spouses.







THE BOARD of Trustees breakfasted together every morning.







Reference

Committee

Meetings









Section

Meetings











At the President's Reception











And the

Trustees'

Dinner



















DR. Fred Smith, Jr., Tell City (right), IMPAC Chairman, with Mr. Max Friedersdorf, former Hoosier newspaperman who accompanied Mr. Rumsfeld from Washington.

MR. Donald Rumsfeld, Counsellor to President Nixon, addressed the IMPAC luncheon on Tuesday.











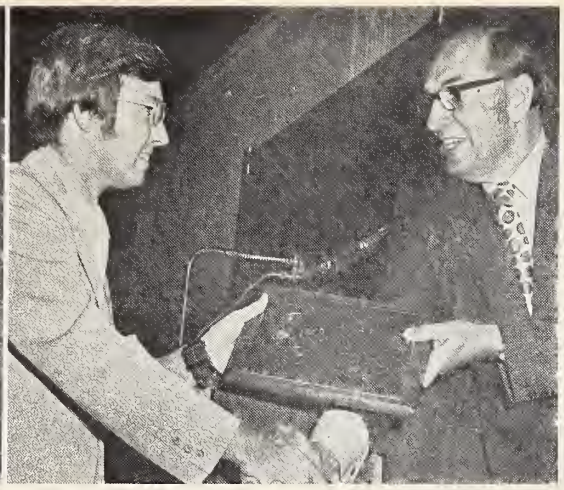


A list of scientific award winners appears on page 1338.

















AWARDS made at the President's luncheon included public relations awards to Leila Holmes, Indianapolis Star; Radio Station WIMS, Michigan City, WFIE-TV; Evansville, and Mr. Jack Rusche, Evansville.

DR. Robert P. Acher, Greensburg, received the "Mental Health Award naming him "Physician of the Year, and Dr. Henry M.S. Bristol, Terre Haute, was chosen to receive the Physician's Community Service Award, also known as the A. H. Robins Award.

INCOMING President Petrich presented the President's Plaque to outgoing President Scamahorn.









Convention Election Results

Dr. James H. Gosman Named President-Elect

Dr. James H. Gosman, Indianapolis, was elected president-elect of the Indiana State Medical Association at the closing session of the House of Delegates in October. He succeeds Dr. Peter R. Petrich, Attica, who was installed as president on October 14.

(An account of the career and service to organized medicine of Doctor Petrich appeared in the November *Journal.*)

Drs. Lester H. Hoyt and Hugh K. Thatcher, both of Indianapolis, were re-elected treasurer and assistant treasurer, respectively.

Dr. Joe Dukes, Dugger, was re-elected chairman of the Board of Trustees, while Dr. Donald M. Kerr of Bedford was re-elected chairman of the Executive Committee.

New trustees chosen for three-year terms by their districts are: Dr. Jack E. Shields, Brownstown, District 4; Dr. John O. Butler, Indianapolis, District 7; and Dr. G. Beach Gattman, Elkhart, District 13. Dr. Paul Inlow, Shelbyville, was elected to fill the unexpired term of Dr. Stephen D. Smith; and Drs. Gilbert Wilhelmus, Evansville, and Vincent J. Santare, Munster, were re-elected to three-year terms, representing Districts 1 and 10, respectively.

Newly elected alternate trustees are: Drs. Thomas Neathamer, Jeffersonville, District 3; Howard Jackson, Madison, District 4; Joseph F. Ferrara, Franklin, District 7; Max Hoffman, Covington, District 9; and Donald S. Chamberlain, South Bend, District 13.

Dr. Betty Dukes, Dugger, was re-elected alternate trustee for District 2.

New Section Officers

Results of the various Section elections are as follows:

Section on Surgery: Chairman—Joe G. Jontz, Fort Wayne; Vice-chairman—Malcolm L. Wrege, Indianapolis; Secretary—J. Robert Edwards, Auburn.

Section on Internal Medicine: Chairman—D. Edmund Storey, Indianapolis; Vice-chairman—John L. Ferry, Hammond; Secretary—Chas. W. Magnuson, South Bend.

Section on General Practice: Chairman—Robert Acher, Greensburg; Vice-chairman—James T. Anderson, Greenfield; Secretary—James R. Daggy, Richmond.

Section on Obstetrics and Gynecology: Chairman—Jerome F. Doss, Kokomo; Vice-chairman—David E. Copher, Indianapolis; Secretary—Charles R. Thomas, Indianapolis.

Section on Ophthalmology and Otolaryngology: Chairman—Kenneth Isenogle, Fort Wayne; Vice-chairman—Wallace Dyer, Evansville; Secretary—David Kenney, Indianapolis.

Section on Anesthesiology: Chairman—John H. Smith, Greenfield; Vice-chairman—C. Herbert Spencer, Fort Wayne; Secretary—David P. Lehman, Kokomo.

Section on Public Health and Preventive Medicine: Chairman—James S. Robertson, Plymouth; Vice-chairman—Fred Poehler, La Fontaine; Secretary—David Edwards, Indianapolis.

Section on Radiology: Chairman—Donald R. Taylor, Muncie; Vice-chairman—Dale B. Parshall, Elkhart; Secretary—L. Ray Stewart, Evansville.

Section on Nervous and Mental Diseases: Chairman—Glen Harris, South Bend; Vice-chairman—John E. Kooiker, Indianapolis; Secretary—Sara Charles, Notre Dame.

Section on Pathology and Forensic Medicine: Chairman—Clyde Culbertson, Indianapolis; Secretary—Victor Muller, Indianapolis.

Section on Pediatrics: Chairman—George F. Parker, Indianapolis; Vice-chairman—Wendell E. Brown, Indianapolis; Secretary—Donald L. Rogers, Indianapolis.

Section on Directors of Medical Education: Chairman—Franklin A. Bryan, Fort Wayne; Vice-chairman—H. William Gillen, Indianapolis; Secretary—Lindley Wagner, Lafayette.

Section on Cutaneous Medicine: Chairman—Jere D. Guin, Kokomo; Vice-chairman—Howard R. Gray, Indianapolis; Secretary—Victor G. Hackney, Indianapolis.

Section on College Health Physicians: Chairman—John Miller, Bloomington; Secretary—Wayne G. Pippenger, Muncie. ◄



THE WINNERS—122nd Annual Convention Indianapolis, Oct. 12-14, 1971

ART AND HOBBY SHOW

Class I - Art

1st Prize:

1. "Windy City Marina" (oil), Dr. R. E. Hannemann, West Lafayette
2. "Flower and Bird" (water color on silk), Dr. W. P. Loh, Gary

2nd Prize:

"Grapes and Red Bird" (water color on silk), Dr. W. P. Loh, Gary

3rd Prize:

1. Untitled (oil), Mrs. R. Schumacher, Indianapolis
2. "Chiquaqua" (oil), Mrs. Harry Siderys, Indianapolis

Class II - Hobby

1st Prize:

1. Wood Sculpture (untitled), Dr. C. S. Wainscott, Indianapolis
2. Painted Stone Exhibit, Dr. and Mrs. J. Kelley, West Lafayette

2nd Prize:

1. Papier mache "Three Wise Men," Mrs. H. Halbrook, Indianapolis
2. Walnut Goblet, Mrs. Jan Mershon, Indianapolis
3. Candlestick (wood), Dr. H. L. Sedam, Indianapolis

Honorable Mention

"Plastic Zoo," Dr. R. Morrical, Logansport

Class III - Photography

1st Prize:

"Mirror Image," Dr. R. McAdams, Lafayette

2nd Prize:

"Hoosier Harvest," Dr. R. E. Hannemann, West Lafayette

3rd Prize:

"Griffin Lake," Dr. R. McAdams, Lafayette

Class IV - Special (Woman's Auxiliary)

1st Prize:

Egg Craft, Mary Kay Moriarty, Indianapolis

SCIENTIFIC EXHIBIT AWARD WINNERS

Award No. 1—Robert L. Dilts, M.D., Indianapolis—Aesculapius Award, courtesy of Eli Lilly & Company—ISCHEMIC LIMB DISEASE.

Award No. 2—David McMullen Smith, M.D., Indianapolis—OSTEOPOROSIS: WILL YOU GET IT?

Award No. 3—Allan A. Katzberg, Ph.D., Indianapolis—EPIDERMAL DYNAMICS.

GOLF TOURNAMENT

Low Gross: Dr. Joseph E. Ball, Indianapolis
Low Net: Dr. Paul Lindenborg, Indianapolis

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1971

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House of Delegates Proceedings

October 12-14, 1971
INDIANAPOLIS SESSION

The first meeting of the House of Delegates convened at 9 a.m., Tuesday, October 12, 1971, in the Red Fez Room of the Shrine Club, Indianapolis, with Dr. Malcolm O. Scamahorn, president of the Indiana State Medical Association, presiding.

The second and final meeting of the House was convened at 2 p.m., Thursday, October 14, in the Ballroom of the Shrine Club, Indianapolis.

Invocation by Rev. Ben Strasser, Christian Church (Disciples), Pittsboro.

Report of the Credentials Committee

Dr. Leslie M. Baker, chairman of the Credentials Committee reported 107 delegates, 9 alternate delegates, 13 trustees, 7 alternate trustees, 7 past presidents and 4 officers were present. The chair announced that, inasmuch as 50 constitutes a quorum, there was a quorum present for both sessions of the House.

In Memoriam

Following is a list of members of the Indiana State Medical Association who were members of the House of Delegates or who served the Association in an official capacity and who have died since the 1970 annual session. The House stood in memory and tribute to the following:

MILO K. AIKEN, Plainfield
RICHARD M. ANDERSON, Vincennes
MILTON O. BEEBE, Rockville
HENRY E. BIBLER, Muncie
WALTER C. BOND, Clay City
LOUIS BYRNE, Bloomington
W. DONALD CLOSE, Indianapolis
DONALD W. BRODIE, Indianapolis
HOWARD W. BYRN, Oxford
PAUL D. CRIMM, Evansville
LESTER G. ERICKSEN, South Bend
JESSE P. GALBRETH, Burnettsville
MAX M. GITLIN, Bluffton
FREDERICK G. GREENE, Seelyville
EDMUND B. HAGGARD, Indianapolis
HOMER G. HAMER, Indianapolis
ELDRED F. HARDTKE, Bloomington
CLOYN R. HERD, Peru
LLOYD W. HISRICH, Batesville
ROBERT G. JOHNSTON, Huntington
ELI S. (JACK) JONES, Hammond
WALTER U. KENNEDY, New Castle
JANE M. KETCHAM, Indianapolis
GOYT O. LARSON, LaPorte
JAMES B. MAPLE, Sullivan
ROBERT J. MASTERS, Indianapolis
ERNEST O. NAY, Terre Haute
HAROLD J. NORTON, Columbus
HAROLD NUGEN, Auburn
DAVID D. OAK, Sr., LaCrosse
ROBERT H. PIERSON, Crawfordsville
WILLIAM C. REED, Bloomington
GEORGE L. REGAN, Sellersburg
JOSEPH W. RICKETTS, Orman Beach, Florida
WILLIAM D. SCHARBROUGH, Ewing
HOWARD H. ROWE, Rochester
HOWARD E. SWEET, Richmond
LOURING W. VORE, Plymouth
GERALD T. WATTERSON, Connersville
HERBERT C. WURSTER, Mishawaka

Approval of Minutes

The proceedings of the 121st annual meeting of the House of Delegates held in South Bend, Indiana and published in the December 1970 JOURNAL of the Indiana State Medical Association were approved upon motion duly made, seconded and carried.

Introduction of Guests

The president introduced Dr. Wesley W. Hall, President of the American Medical Association, Dr. Harry W. Weeks, Jr., President of West Virginia State Medical Society, Dr. P. John Robechek, President of Ohio State Medical Association, Dr. John S. Harter, President of Kentucky Medical Association, Dr. C. J. Jannings, First Vice-President, Illinois State Medical Society and Dr. Francis N. Lohrenz, guest speaker, Marshfield, Wisconsin.

Address of the President

HOUSE ACTION: Approved and commends him for his twelve recommendations. Referred to the Board of Trustees for implementation.

As your president representing you, the membership, I have covered Indiana from Gary to Lawrenceburg, Evansville to Angola, and lots of stops in between.

With your AMA delegation I have traveled to national meetings from Boston to San Francisco.

Wherever I have been I have tried sincerely to serve you individually and collectively to the best of my ability.

At all times I have been sensitive to your thoughts, your questions, your criticisms (both constructive and otherwise).

I have been impressed with your sincere love and concern for your patients and the compassionate position of the medical practitioner in our Indiana culture.

So, in opening this House of Delegates I would like to speak on the major problems that, I feel, face medicine today.

Because of recent publicity, we can all name the problem of manpower.

Others are: the cost of medical care (including fee restriction), national health care financing insurance, financial problem of the existing and new medical schools, drug and alcohol abuse, mental health, pollution, care of the poor, patient and public education, quality of care, modernization of health and health-care facilities and, finally, professional liability.

Some of these are discussed in my supplemental report filed with the House along with recommendations to the local society and some for the House approval.

As you may notice, many of these problems have been studied by our committees and commissions and their reports are for your consideration.

Manpower embraces both that of physician and allied health personnel—recruiting, productivity, efficiency and distribution.

For the main part, M.D. manpower problems are maldistribution (both geographical and specialty-wise) allied with some productivity problems.

In the U.S. since 1965, there has been an almost 40,000 increase in M.D.'s, and in the last 20 years there has been an increase of almost 50% in the total number of phy-

sicians while the united States population has increased a little over 30%.

When one talks with the public about manpower problems, the public asks immediately for more persons to provide primary health care—that is, a medical person who can be contacted by the public directly for treatment and/or advice and not have to be referred by or to another physician.

Traditionally, this, of course, has always been the general practitioner; however, many other specialists now embrace care under the title of generalist or primary physician.

In the last seven years the number of specialists and subspecialists have increased about 25% in the United States.

Pediatricians have increased 16%; obstetricians-gynecologists have increased 17%, while the number of general practitioners has decreased 25%.

Actually, the net result is that, despite specialization, primary-care providers are not disappearing.

These providers are now 56% of all office-based M.D.s in America and are joined by some few others of the varied fields who do render direct patient care.

In Indiana almost the same pattern is present. In the last 10 years we have gained 650 M.D.s. The number of non-patient-care M.D.s—such as teachers, private laboratory researchers and administration M.D.s—have increased about 130.

Hospital-based practitioners, namely, interns and residents, I am happy to say, have increased to 130.

Patient-care M.D.s have increased over 400.

Surgery has remained the same.

The medical specialties have increased 138, the other specialties 240, while general practitioners have decreased 208.

Many of these G.P.s are from the smaller towns that previously had only one or two M.D.'s.

To repeat, the real problem, in my opinion, is the tendency towards specialization and the understandable desire of many physicians to live and practice in areas which have the most advantages and which are the most pleasant to reside in.

M.D. manpower has become a popular and emotionally charged cause recently in Indiana.

You know, Americans have a certain fad about public causes.

May I remind you that a few years ago we were upset about ethnic and racial discrimination.

Public opinion became so strong that government reacted and now we realize that student busing is not the answer for school desegregation.

Then came malnutrition, and the political candidates paraded across our T.V. screens with this problem as their white horse.

Government reacted again and now we have liberalized welfare laws and an expanded food stamp program which, in my opinion, does not seem to be the answer for this problem.

On the crest of these agitation curves, quite often exaggerated statements are made; unknowledgeable persons become experts.

Perils are overexaggerated and emotions are stirred and unwise solutions often recommended and, indeed, government reacts.

When public clamour subsides, public discussion usually can proceed unhampered. It is always sounder to make decisions and formulate better plans in this atmosphere. I hope that the question of medical manpower in Indiana is now and will remain in this quieter, sensible arena.

Your ISMA has been active in and has supported many programs which will obtain and retain more qualified physicians for Indiana.

In our plans for the public are continued concern and support of reasonable solutions which will bring qualified M.D.s to Indiana; however, local M.D.s and the public must work together for a worthwhile, valid solution.

In considering the shortage of manpower, we are dealing with one of the most urgent and important questions in our history. The great pressure of public discontent is reflected in increasing support for drastic changes.

A few years ago, advocacy of a national health insurance plan or any comprehensive national health scheme would have been considered by the public to be socialistic nonsense, but not today.

Physicians are at the heart of the health care industry—obligated by compassion, training, and tradition to the public and by responsibility to themselves to become involved. We must give leadership to responsible solution. Specifically, the fianancing of health-care insurance is before congress.

Presently there are some 15 proposed laws for national health-care insurance.

Some "wag" recently said, that, in his opinion, the best way to better health care might be to get the politicians off the medical people's back and let the doctors go back to tending the sick.

Our critics, the proponents of those all-encompassing plans, try to scare the people into believing a health crisis exists and that the plans they propose will improve the nation's health at little or no cost to the recipient.

A visitor from another planet would expect to find waiting lines for days for people to get primary care; serious and contagious diseases running rampant; mortality and morbidity rates skyrocketing; perhaps even people dying in the streets—if indeed a crisis does exist.

Their argumentative proof usually resolves to two items.

(1) availability of health care, again the question of manpower; and

(2) the cost of care.

The promise implies that by overthrowing this cottage industry, this non-system, this fee-for-service system that has given America its medical care leadership and embracing an inverted system of collectivized physicians' assembly-line, mass-produced care with no concern by the recipient for payment, that a health-care miracle will happen.

This is oversimplification. Medicine does have some problem areas but just restructuring the system of health care is not the answer.

The critic's argument further goes on with such statements as, "The doctor bills of $3,000, $6,00 are too high." What the critic means is that catastrophic illness, or an accident, causes a health-care bill beyond the person's capabilities. The public must recognize and separate the M.D. fee from institutional costs. Doctors' fees are seldom over 15% of health-care charges.

I do recommend that this association support some form of catastrophic insurance for large health-care costs.

In my opinion, this type of insurance should have been passed instead of Medicare and it would have served the public better.

I endorse the guidelines. I urge that this association endorse the guidelines for national health-care insurance as prepared by AMA and go forth to political battle with these guidelines—not a fixed position.

Just eight days ago the headlines of the Indianapolis Star stated that a study of the doctor bills would be involved in Phase Two of the government's inflation program but, once again, the report had lumped all health-care costs together. Public education, as I said, is a must.

Let's look at the record for a moment—about M.D. fees.

Under Title XI and Title XIX, welfare programs in Indiana, mind you, from January 1 to August 31, 1971, only 9.6% of the total dollars paid went to M.D.s.

This represented $20 per claim which, incidentally, was more than $4 less than the amount per claim paid to the chiropractors.

Universally, as well as in Indiana, Medicare total dollars paid to M.D.s usually are less than 11% of the total bill.

Our critics further speak of M.D. fees leading the increases on the consumer index.

True, but the consumer index contains cost of manufactured goods and so forth, as well as services, and to compare M.D. fees with the consumer index is like comparing apples and oranges.

M.D. fees have gone up 8% in the last 12 months, to my calculation, but water and sewage rates, taxi fares, intercity bus rates and painting a room have gone up anywhere from 13 to 20% — not to mention the recent large percentage increases in the postal rates.

U.S. News and World Report recently stated that over the last five-year period, M.D. fees were up 37% while auto insurance rates were up 38%; and cost of replacement of the kitchen sink were up 40%.

Today in Cincinnati the M.D. fee for an appendectomy costs 38 hours of pay for a construction worker, while in 1965 he had to work 47 hours for this same fee.

But, for a moment, let me defend hospital costs, despite their tremendous increase. In 1960 the national average-per-day cost of hospitalization was $33. In 1970 it was $81, although the Indiana average was only $69 last year. The largest expenditure is labor and it represents in 1970, $48 of the $81.

But more importantly, this increase represents the offering of many costly new services.

In 1960, only 10% of the short-term, non-federal hospitals had intensive care units. But, today, in the same reporting hospitals 38% have coronary care units: 44% have intensive care units; 52% have inhalation therapy; 12% have renal dialysis; 13% have in and out patient psychiatry; and open-heart surgery is available in seven.

These are all new services—not available in 1960—so you see hospital costs represent a different, more productive service than was offered 10 years ago. Your association must ask its members to be aware of hospital costs and act to lower costs while maintaining the quality of service. Obviously, cutting M.D. fees will not substantially lower the health-care costs, but we must attempt to minimize the number of hospital and institutional care days. Utilization review is doing and will do this. But, again, public education to help in this matter is necessary.

Secondly, the public must change its health habits to minimize health expenditures for the service of unavoidable illness.

No less an authority than the New York Times said editorially on June 27: "Millions of Americans woudd benefit more from changing their dietary habits, losing weight, exercising, stopping cigarette smoking, and cutting down or ending their alcohol consumption and that of other drugs than from having more physicians and more hospitals available to treat them after their bad habits have laid them low."

A recent magazine article did commend this profession for lowering the hospital days per illness to the lowest since World War II; but then, later on in the article, they criticized the terrible increase in out patient laboratory and x-ray use. Our critics, you see, would probably only be satisfied by not having sick people at all.

I have talked only of about three of the most serious problems, but in this House let's talks as brothers and work together as the medical family of Indiana to solve the problems that face us. I want medicine to be the leader in the formation of the design of the path which health care will take in the years ahead. To allow anything else to occur would be an abdication of our responsibilities to ourselves as well as the citizens of Indiana whom we serve.

I have no patience with those who say, "Well, since it's coming, we might as well join in."

The challenges are before us; the time is NOW—at this house of delegates.

Let's begin, and, as the conductor used to shout, "All aboard!"

Supplemental Report of the President

HOUSE ACTION: Approved and referred to the Board of Trustees for implementation.

I call attention to the executive secretary's report which advises you as to the disposition of the actions of the 1970 House of Delegates of ISMA. The Board of Trustees, the various committees and commissions and officers have made a sincere effort to implement your wishes.

Allied with these implementations are actions in other fields. Some of these are re-establishment of a Medical-Legal Review Committee at the state level and sincere meaningful talks with the Indiana State Bar Association, continued cooperation and a bilateral information exchange with the Indiana State Hospital Association, a leadership conference, maternal and child care study group, greater medical student liaison, the use of the computer for a detailed and better audit of ISMA funds, more and better services being offered to the local medical society through additional staff and the WATS line, a joint meeting with the Osteopathic Association officers, and offering our headquarter's services to the specialty groups and the acceptance of the same by some of the specialty groups.

My sincere wish, while the president of the Association, was to visit as many of the local societies as possible, not to mention all the usual Association-related meetings. To this end, I have been guest at approximately one-third of the local societies and all of the district societies in the six sister states. Our ISMA problems are similar to those throughout the midwest and problems of various regions of the state are similar to other regions. District meetings can and must become more effective. The district state officer can bring to the individual physician and his local society information as to what the state and national medical organizations are doing about his problem; therefore, I recommend that over a three-year period the president and the president-elect, accompanied by the appropriate trustee and a staff fieldman, visit every local medical society.

To better bridge the gap between the membership and the established policy of the State Medical Association, I further recommend that the Board of Trustees cause a policy manual for the State Association to be prepared in a manner to allow periodical updating and that, when completed, it be distributed to the local society and to its officers as well as to interested membership.

Medical manpower is and will be a very grave problem, and your state Association has regularly and must continue to be concerned for our citizenry. I urge that the local medical society join interested groups to solve this problem on a local level. I recommend that each local society contact and keep liaison with the medical students from that county wherever they may be attending medical school. In my opinion, these two actions will help to locate the graduate M.D. back in this specific area.

An allied problem is the public need for emergency medical coverage or, at least, information on how to get medical coverage. Once again, I recommend that each local society establish emergency care plans, if they do not have plans for this specific region and that its implementation

be known to the public. To this end, ISMA and the local societies must educate the public as to what constitutes an emergency and how to seek medical help.

The public is more and more knowledgeable and concerned about health care. The doctors of Indiana are doing a good job of caring for the citizens, but our story must be told. The day of the glib-talking, cockhatted press agent is gone but I recommend that an effective and meaningful program, financially supported, be mounted to counteract some of the scare and unfavorable materials now being presented against the doctors in Indiana.

With the government payments and third-party payments totaling over 60% of all the health-care costs, individually and collectively, physicians are subjected repeatedly to information collected by the third parties. I recommend that ISMA become involved individually or with other individual groups to gather meaningful information regarding all aspects of health care as rendered in our state today. This could also easily move over into such services as billing, filling out insurance forms, and so forth, for our members.

A survey made by the ISMA membership this year, with an almost 50% return, shows conclusively that additional services are desired by the membership. Insurance of all kinds, providing of car leases, medical equipment purchases, group travel and group air charter lead the items desired. I recommend that ISMA services expand into these desired fields. (A copy of the questionnaire is enclosed.)

A different service that should be developed by the Association which would help the physician members directly and our patients indirectly is stressing increased productivity of the practitioner and efficiency in direct patient care. I propose the proper commission be charged with using outside help, if necessary, to prepare a training program for the members and their non-M.D. staff, in human relations, including the use of telephones, office service care, how to train and educate patients in health care, efficient improvement of his office records, both professional and business. This program could then be offered to the interested members. The State Legislature now meets in yearly session and, with more attention being given to medical matters, I recommend that financial support be given to more staff for coverage and that consideration be given to part-time residence of physician-members in Indianapolis during the sessions. This is a must to tell medicine's story to the lawmakers of Indiana and having men available and prepared to give the lawmakers information on medical matters.

ISMA-AMA relations are very good; 79.6% of the physicians in Indiana are AMA members. This ranks Indiana fifth among the 50 states. It is interesting to observe that the four other states are less populated than Indiana. Many of our members hold important AMA positions; this is a compliment to these men, to our fine AMA delegation, and I urge this House of Delegates to commend the delegates and the alternate delegates to AMA for their efforts on behalf of the Indiana physicians. The delegation must continue to have the active, knowledgeable, dedicated men who can sacrifice the time and loss of income to serve their Indiana colleagues.

MALCOLM O. SCAMAHORN, M.D.,
President

Remarks of President Scamahorn

Any delegate may introduce a resolution from the floor, provided that where a resolution has been first submitted to the Committee on Rules and Order of Business together with a written statement setting forth the reasons why said resolution was not mailed to the Executive Secretary more than 45 days prior to the meeting of the House of Delegates and also setting forth in said written statement the reason why said resolution is of such an emergency nature that it cannot wait until the next meeting of the House, and that said Committee on Rules and Order of Business has approved said resolution for submission to the House, and that each delegate shall be furnished a copy before the next meeting of the House, then this subsection of the Bylaws may be suspended with respect to said resolution upon a two-thirds vote of the House of Delegates.

Committee on Rules and Order of Business is in session at the rear of the Red Fez Room.

Appointment of Reference Committees

In accordance with the Bylaws, I have appointed reference committees, and the names of the members of these committees are published in the Handbook.

These reference committees are to serve during this annual convention only and should not be confused with the commissions or standing committees of this Association.

To these reference committees will be referred all reports, resolutions and measures presented to the House of Delegates at this session, except such matters as properly come before the Board, and the recommendations of these committees shall be submitted at the final meeting of the House of Delegates at 2 p.m., Thursday, October 14, for acceptance in the original or modified form, or for rejection. The Thursday afternoon meeting will be held in the Ballroom of the Shrine Club.

Each reference committee consists of five members, the first member named is chairman. Will committee members please stand as their names are called?

REFERENCE COMMITTEE NO. 1

Malcolm L. Wrege, Indianapolis (Marion), *Chairman*
Howard R. Marvel, Indianapolis (Tippecanoe)
Eric Clark, Plainfield (Hendricks)
Charles Egnatz, Schererville (Lake)
Glen McClure, Sullivan (Sullivan)

REFERENCE COMMITTEE NO. 2

Marvin E. Priddy, Fort Wayne (Allen), *Chairman*
Ross Egger, Daleville (Delaware-Blackford)
Arvine G. Popplewell, Indianapolis (Marion)
L. W. Neal, Munster (Lake)
Thomas J. Conway, Terre Haute (Vigo)

REFERENCE COMMITTEE NO. 3

John D. Wilson, Evansville (Vanderburgh), *Chairman*
J. Robert Edwards, Auburn (DeKalb)
Kenneth Ahler, Rensselaer (Jasper)
Fred W. Dahling, New Haven (Allen)
Kenneth Schneider, Columbus (Bartholomew-Brown)

REFERENCE COMMITTEE NO. 4

Max N. Hoffman, Covington (Fountain-Warren), *Chairman*
Alvin J. Haley, Fort Wayne (Allen)
David H. Jones, Charlestown (Clark)
L. John Vogel, Mt. Vernon (Posey)
I. E. Michael, Indianapolis (Marion)

REFERENCE COMMITTEE NO. 5

Loren H. Martin, Indianapolis (Marion), *Chairman*
Martin J. O'Neill, Valparaiso (Porter)
Robert Rose, Spencer (Owen)
James Fitzpatriek, Portland (Jay)
Carlos M. Ruiz, Boonville (Warrick)

TELLERS

Robert M. Brown, Marion (Grant), *Chairman*
Donald E. Stephens, Indianapolis (Marion)
Joseph Young, Greenwood (Johnson)
Glen Ward Lee, Richmond (Wayne-Union)

Resolution in Tribute to Dr. G. O. Larson

WHEREAS, Dr. G. O. Larson has served the medical profession and the ISMA long and faithfully; and

WHEREAS, he has distinguished himself by his wise counsel and dynamic leadership and as president of this association in 1968, and

WHEREAS, his untimely death has saddened us all by the loss of our true friend and great physician,

NOW, THEREFORE, BE IT RESOLVED that this House of Delegates forward to Mrs. Gladys Larson this resolution of our great respect and sadness at the loss of our friend and colleague.

Election of Officers

OFFICERS: Dr. Peter R. Petrich of Attica assumed the office of president and Dr. James H. Gosman of Indianapolis, was elected president-elect.

Dr. Lester H. Hoyt, Indianapolis, was re-elected treasurer by acclamation.

Dr. Hugh K. Thatcher, Jr., Indianapolis, was re-elected assistant treasurer.

Dr. Joe Dukes, Dugger, was re-elected chairman of the Board of Trustees. Dr. Donald M. Kerr, Bedford, was re-elected chairman of the Executive Committee and Dr. Wilbert McIntosh, Riley, was re-elected a member of the Executive Committee.

ELECTION OF TRUSTEES: Three new trustees elected in 1971 were: Dr. Jack E. Shields, Brownstown, Fourth District, Dr. John O. Butler, Indianapolis, Seventh District and G. Beach Gattman, Elkhart, Thirteenth District. Drs. Gilbert Wilhelmus, Evansville, First District and Vincent J. Santare, Munster, Tenth District, were re-elected. Dr. Paul M. Inlow, Shelbyville, Sixth District, will fill the unexpired term of Dr. Stephen Smith, formerly of Knightstown, who resigned.

Newly elected alternate trustees were Drs. Thomas Neathamer, Jeffersonville, Third District, Max N. Hoffman, Covington, Ninth District and Walter D. Griest, Fort Wayne, Twelfth District. Drs. Betty Dukes, Dugger, Second District and James A. Harshman, Kokomo, Eleventh District, were re-elected. Dr. Joseph F. Ferrara, Franklin, Seventh District, was elected to fill the unexpired term of Dr. John O. Butler, Indianapolis.

AMA DELEGATES AND ALTERNATE DELEGATES: The following were elected to a two-year term as delegate and alternate delegate to the American Medical Association, their terms to expire December 31, 1973:

Delegate, Dr. Jack E. Shields, Brownstown; alternate, Patrick J.V. Corcoran, Evansville; delegate, Dr. Lowell H. Steen, Hammond and alternate, Dr. Thomas C. Tyrrell, Hammond.

Dr. James A. Harshman, Kokomo, was elected delegate to fill the unexpired term of Dr. Donald E. Wood, Indianapolis, who resigned. Dr. A. Alan Fischer, Indianapolis, was elected alternate delegate to fill the unexpired term of Dr. James A. Harshman, Kokomo, who resigned. These terms expire December 31, 1972.

Emergency Resolution to change name of Section on General Practice

HOUSE ACTION: Introduced in 1971 and will not be up for approval until 1972.

WHEREAS, the American Academy of General Practice, meeting in Miami, Florida, October 2, 3, 4, 1971, officially changed the name of the organization to the American Academy of Family Physicians; and

WHEREAS, at that exact moment the Indiana Academy of General Practice became the Indiana Academy of Family Physicians; and

WHEREAS, the above name change more adequately describes the role and function of the present day generalist.

NOW, THEREFORE, BE IT RESOLVED, that the name of the above mentioned section be changed to the Section of Family Physicians.

Supplemental Report of Board of Trustees Regarding Blue Cross Forming HMOs

HOUSE ACTION: Adopted.

The Board of Trustees received at their meeting this morning word that Blue Cross was planning to develop HMOs through this organization. The position members of the Blue Cross Board were asked to express strong opposition to the creation of HMOs through this organization. The Board of Trustees feels the concept of Health Maintenance Organizations will do nothing but develop prepaid capitation closed panel practice and that such systems will lead to a monolithic system of health service delivery. Therefore, we have asked our representative to oppose this concept and, if they are unable to convince this board this is wrong, then we should file a minority report. The Board requests that the House of Delegates concur with this decision.

Amendments to the Constitution

HOUSE ACTION: Adopted.

Be It Resolved that Article VI of the Constitution be amended by deleting the last sentence of the Article which reads "seven trustees shall constitute a quorum" and insert in lieu thereof "A majority of elected trustees shall constitute a quorum."

Be It Resolved that the present Section 3 of Article VIII be deleted and the following be inserted in lieu thereof: "Section 3. Special meetings of either the association or the House of Delegates shall be called by the president upon receipt of a petition signed by thirty delegates or one hundred members. The signed petition shall contain the names of at least ten delegates or thirty-four members from each of at least three Board districts. Upon receipt by the president of such a petition, the president shall within thirty days thereafter issue a call for such special meeting at a time and place to be fixed by the president. The president, in specifying the time of such special meeting, shall fix the same as soon thereafter as reasonable and suitable arrangements can be made."

Be It Resolved that Article IX, Section 1, be amended by striking the "thirteen" and inserting in lieu thereof the word "the" which will then make Section 1 read as follows: "Section 1 - The officers of this Association shall be a President, a President-elect, an Executive Secretary, a Treasurer, an Assistant Treasurer and the Trustees, each of whom shall be a member, except the Executive Secretary, who need not necessarily be either a physician or a member."

Be It Resolved that Article IX, Section 4, be amended by striking the word "Trustee" in the first sentence and inserting in lieu thereof the following:
"Trustee(s) or alternate Trustee(s)" which will make Section 4 then read as follows: "Section 4 - The Trustees shall be elected by the respective district societies. If any district fails to meet and elect its Trustee(s) or alternate Trustee(s) by the time of the expiration of the incumbent's term of office, the Executive Secretary of the Association shall cause a special meeting to be called by said district society for the purpose of such election."

Be It Resolved that Article IX, Section 5 be amended by striking the word "an" in the first sentence and adding after the word Trustee "(s)" which will make Section 5 then read as follows: "Section 5. Each Trustee district shall elect alternate Trustee(s) whose term of office shall be the same as the Trustee, namely three years. The Alternate Trustee shall be elected in a year during which there is no Trustee elected.

"The duties of the alternate Trustee shall be:

1. To represent the Trustee district in the absence of the regularly elected Trustee.

2. To vote only in the absence of the regularly elected Trustee either in the House of Delegates or in Board meetings where he represents the regularly elected Trustee."

Address of President-Elect Peter R. Petrich

HOUSE ACTION: Approved.

Members of the House of Delegates, ladies and gentlemen, guests: It is indeed a privilege for me to speak with you today as your president-elect. At the time one achieves this position through the voting of you people, the emotional response you feel is very strong and it precludes making a proper thanks to those assembled. The many who have been there know what I mean and I hope that many of you will have the opportunity to experience this feeling. Today, I want to take the opportunity to offer my sincere thanks and appreciation for the opportunity to continue to serve you as president-elect and next year as your president. I hope that I will be worthy of this high office.

In the same vein, it is customary to wait until our last meeting to read a commendatory resolution thanking our outgoing president. Today I would like to deviate from that custom and I want you to signify to Malcolm Scamahorn our appreciation for the untiring and dedicated year he has devoted to organized medicine. No one has been more interested, enthusiastic, or available to the membership and the activities of Indiana State Medical Association.

Now I would like to bring you up to date, briefly, on my activities as president-elect. I began my appointments to committees and commissions early in the summer with the idea in mind that "our year" of action in ISMA very often only really extends from January to October. The scope and extent of our work requires a full year of effort on all our parts. I felt that if all the organization possible would take place early, then perhaps we would begin functioning immediately after the state meeting. Almost all appointments are made now, and I will meet with the chairmen of the committees and the commissions this week. The relative success or failure of this effort should soon be apparent. I hope that it's crowned by immeasurable success.

I will now announce that the Board of Trustees consented to a proposal of mine at a recent meeting that the format of the County Society Officers' Meeting be changed this year. The meeting is open this year, not only to the county society officers, but to the members of the House of Delegates, the Board of Trustees, the AMA delegation, and all other interested members of ISMA. The program will deal with computers in medicine in all of its facets. There will be a demonstration of many types of operative programs. At the present time we have approximately 19 or 20 diverse companies who are bringing in their materials for exhibit on Saturday, November 13. In addition, there will be a formal presentation by some fine minds in this area on Sunday morning, the 14th. It will take place at the Marott Hotel and further details will be mailed to you all in the very near future.

The Board of Trustees also consented to having our Commission on Medical Education and Licensure meet with you in several areas of the state to exchange ideas regarding a new Medical Practice Act. This is based on a national model which comes from the federation of the State Boards of Examination. Additional information regarding this will also be forthcoming from the Chairman of that Commission. I would urge you to participate to the fullest in the activities that I have just reported to you.

And now, for just a few moments, I want to wax philosophic, if you will, about something I feel strongly. For too long now we, the physicians in Indiana and in America, have been assailed at every step by almost everyone in an unjustly critical accounting of our professional incompetence, our moral failings, and our personal financial avarice regarding our patients. When we assume a posture of defense, our critics use this as a further ammunition against us: "If not much is wrong, why are you so defensive?" I defy any group to be so vilified and criticized and not respond in similar fashion. Defensive—hell, yes—and completely and justifiably so. But being defensive doesn't win anything and it is time we "about face" and become offensive. I don't mean we should offend people, but we must take our position, our story, our refutation and reputation, if you will, to the people and the politicians. We must do this by positive action on the part of all of us—action in our daily activities, action in politics, action in the field of professional and public relations. We must constantly and convincingly report to all that we are capable, dedicated and interested in the health and welfare of our patients—that no other group knows more than we about the practice of medicine and medical care and that no system of governmental-controlled health care ever provided better or less expensive or more available care than our present system. I agree with Dr. Scamahorn's various suggestions for taking positive action in these areas. Only an alert, active and sacrificing group of physicians through organized medicine can accomplish this positive, offensive goal.

In closing, I want to reiterate my thanks and I will do my very best to continue to serve you in the coming year.

Remarks of Mrs. Stanley M. Chernish, President of the Woman's Auxiliary to the Indiana State Medical Association

HOUSE ACTION: Ordered filed.

The woman's auxiliary to the Indiana State Medical Association. What is it? What is its purpose? What does it do? I have been asked these questions many times, and not necessarily by strangers either. A staff member in the ISMA office asked and — would you believe — my own dear husband. He knows now. But how many of you know?

We have three main purposes: (1) one is to assist the Indiana State Medical Association in its program for the advancement of medicine and public health. (2) to participate in any endeavor at the request of the ISMA. (3) to cultivate friendly relations and promote mutual understanding among physicians' families.

This is a pretty large order but we do it and much more. As of April 1971 our membership totaled 2,675. We would like to have all doctor's wives participating. Is your wife a member?

We are *anxious* for all doctor's wives to join the Auxiliary. This year the national Auxiliary will celebrate it's 50th birthday at the AMA convention in San Francisco. Our goal is 100,000 members by then.

At this point, I would like to tell you about some of the projects we are presently engaged in. One of these is AMA-ERF. This year our County Auxiliaries have worked enthusiastically for AMA-ERF. In 1970 the Auxiliary contributed $21,737.95: this, with your contribution, gave Indiana $47,823.95. A check was sent to the ISMA office for $29,587.59 to be given to Dr. Glenn Irwin, dean of the Indiana Medical School, to use as he saw fit.

To promote health related professions, twenty six organized counties gave $9,423.50 to Health Careers. This will be used for loans and scholarships. The auxiliary also helps the medical students' wives group, WA-SAMA. This year we gave them $200

to defray the travel expenses of their officers to the national convention.

Since 1962 we have contributed $5,000 to the ISMA and an additional $500 this year. This went into a special fund to be used for improvements in the basement of the ISMA building.

To raise these sums of money the ladies have been involved in many projects—such as the sale of Christmas cards and toys, card parties, dances, memorials and in as many other ways as the mind can imagine. The girls have been busy.

The Auxiliary also takes an active part in politics; many of the members serve on election boards and help with the campaign. This year one of our members was invited to serve on the IMPAC board. We are pleased to tell you that Mrs. Beach Gattman was appointed to this position.

In closing, I would like to call your attention to the Auxiliary's page in the ISMA *Journal*. This year I've invited each of my chairman to tell you about her program. Hopefully you will read it and get a better insight into the Auxiliary activities.

This is an exciting year for me, much has been accomplished. *However*, without *your* help and that of all the auxiliary members, none of this would have been possible. I wish to thank the board members of the ISMA and those working in the office for their many kindnesses. A *very special thanks* to Dr. Scamahorn for his patience and understanding. I'm looking forward to working with Dr. Petrich this coming year.

Please feel free to call on the auxiliary. We are ever anxious to be of service to the association.

Remarks of Mr. Norman Fogel, President of the Indiana Chapter, Student American Medical Association

HOUSE ACTION: Ordered filed.

Thank you very much Doctor Scamahorn. It is a real pleasure to have been asked to address this meeting as to what's going on in the Student AMA. I'd like to apologize for not being here earlier but, due to protocol at school, they don't know it's the convention and we had an exam this morning, so you know it's one of those things that had to come first. We are members of the Student AMA and, as such, we've been given a lot of responsibility, not only with our own student body; this year we are starting to spread out and move in with the AMA on many committees. Hopefully our members will not let you down. We've reorganized our leadership because in the past we've had a problem with upper classmen who have been officers in the organization. These people have not had the time or the contact with undergraduates to organize properly what we consider to be a necessary prerequisite for leadership at least as far as the way Indiana University is set up; and so we have sort of gone on a bi-party system and we have two presidents, we have two vice-presidents, a treasurer and a secretary. I'd like to introduce the vice-president, Doug Sheets, who came along with me today. He's in the back of the room.

Just a few facts on where we stand as an organization now. We are the largest single SAMA Chapter in the country. We have over 580 members. This gives us three delegates at our national convention, which has proved to be a pretty big stumping block or, I should say, stumbling block for those who are in opposition; but we kind of enjoy having the power of coming to a convention as one of the biggest schools. This year we've had an excellent membership program for freshmen and as of now we have just about three-fourths of the freshmen class signed up, so we are really looking forward to a good year.

I don't want to belabor you with a lot of trivia but I'd like to tell you of a few plans that we have this year as far as major projects go. One of them that we are going to put on within the next month has to do with community health and interdisciplinary programs and this came to my attention through the national office and through my own experience at school. Medical students are trained to be scientists and clinical specialists but they are never given any sort of program on how to handle and how to cooperate with the paramedical fields that are available. So SAMA has taken upon itself this year to at least establish a program which medical students, nurses, pharmacists and social workers can all get together and rap and discuss what their own problems are (hopefully with the help of their faculty) so that when we get out of school we are not going to be faced with the same problems a lot of you were faced with and we're faced with even as students in a clinic where nurses and people didn't like you because you didn't understand them maybe. So, hopefully, we can get a better understanding with our paramedical help.

We have also on the agenda for next semester a population program in which various forms of contraception and forms of pollution control, etc., will be discussed; so we're kind of spiced up with that. Another program that we have is a SAMA Scholarship program. We are in the midst now of establishing this. SAMA is not rich enough to finance it but we are looking to the community and the state for people who would possibly set up either a trust fund situation or a revolving loan fund for medical students, because from year to year the financial status and the amount of loans available to medical students vary. I know when I first entered school we were given a speech in which we were told that we would not get loans, that we would have to wait until we were sophomores or implied that we were pretty poor risks. SAMA doesn't consider the freshman medical student a poor risk, especially at I.U. The tuition rate is extremely low.

The thing that I would like to conclude with is that we are planning to continue a strong liaison with Doctor Petrich and his new group of officers this year. We do hope that our communications will be better. We've already tried to establish this fact through various channels of communication and in the future I just hope that SAMA and ISMA can both prove to be cooperating organizations.

The MECO program is one of the top SAMA projects. We are going to continue it and we hope for a lot of support from smaller communities. Last year we had nine people participating and, from what I understand, the results were just excellent. I can't stress to you enough, gentlemen—I've participated in this program myself—how important this can be to a small community in establishing relations and getting doctors to get excited about getting out of the ivory tower situation and into the smaller community. I know that within the next few months we will be contacting many of you and many of your hospital administrators in the smaller rural communities and we hope to be able to expand the MECO program way beyond what it is now. Jane Henny is the regional chairman of the MECO program as well as the state chairman.

Report of Chairman of the Blue Shield Board of Directors

HOUSE ACTION: Filed for information.

Mr. President, members of the House, fellow physicians, guests and friends: It is indeed a privilege at this time to present to you Blue Shield's Silver Anniversary report to the physicians of the state of Indiana. I feel this is indeed 25 years of service to the profession and I hope you

will look at it and give us a recommendation for the future.

I am sorry at this time our building is not completed so we could have some guided tours for you, but we will inform you in the future of our formal dedication and welcome you all to come see your Blue Cross-Blue Shield operation. However, Blue Shield is now completely moved and under one roof. I am sure this will show in our efficiency in the future.

I must take this opportunity to brag about our performance and also to admit that we have certain deficiencies and certain problems. Last week Ernst and Ernst completed the audit of our performance for the year of 1970. I don't want to bore you with too many statistics but I would like to give you just a brief analysis of the Ernst report. The total cases audited were 249,526. The cases paid in full were 236,743. Our percentage of cases paid in full 94.88. (I still realize that everyone of you in here still have a case that wasn't paid in full.) Cases partially paid, 12,783. Of this amount the total charges were $1,022,550 and we paid $729,107. The total amount of charges for all cases was $9,682.785. We paid $9,389,142, which is 96.97% of total paid. Also, the evaluation of the time and processing claims came out this way: 76% of all Medicare claims were processed in 20 days; 89% of all Medicaid claims were processed in 20 days. I hope this will give you a little insight into what your Blue Cross-Blue Shield operation is doing. I realize that we have problems, but we are here to serve; we are here to listen to your recommendations. Mr. Kilborn, Mr. Dixon and myself will be here at all times during the sessions and will be happy to discuss problems with you. Thank you.

Reading of Memorial

Doctor Santare asked that the rules be suspended to pass a memorial resolution in tribute to Dr. Eli Sherman (Jack) Jones, as follows:

WHEREAS, Doctor Jones has served the medical profession in the ISMA long and faithfully; and

WHEREAS, he has distinguished himself by his art, wisdom and leadership both as a delegate of this House and delegate to the AMA and as Vice-President of the AMA; and

WHEREAS, his death has saddened us all for loss of our true friend and great physician;

NOW, THEREFORE, BE IT RESOLVED that this House of Delegates forward to Mrs. Bertha Jones this resolution of respect and sadness at the loss of our friend and colleague.

Report of Wesley Hall, M.D., AMA President

Dr. Hall: Thank you very much, Mr. President, members of the house, distinguished guests and my very good friend of long standing, Dr. Ed Annis, who, I think, is probably the most effective man we have ever had in the American Medical Association. The most convincing and one of the most knowledgable. In addition to that, he is one of the most dedicated. Would that we could have a dozen more like him, but I think that when that gentleman upstairs made the pattern he must have lost it after Ed was created, because there are very few Ed Annis that I have seen in the few years that I have been in the practice of medicine—namely, 41½ years.

I don't know of any place that I have had a more cordial reception. I've met so many friends, so many people that I think philosophically and basically are on the same frequency and yet friends of mine. We have had periods of disagreement but the interesting thing about it is that I think we, as physicians and as American citizens, should be able to disagree without being too disagreeable. I think we can do this in medicine, we must do it. I'm speaking to you this afternoon somewhat in a little dilemma and torn between mixed emotions. I wonder whether to be too serious and bring you the gloomy side of medicine and the things that I see or the bright side of medicine. I feel a little like the father who was awakened at three-thirty in the morning and in a rather sleepy state stumbled down the stairs and lets in his 17-year old daughter and she has a Gideon Bible under her arm.

You know this medicine is a rather fascinating profession, but we have our problems, as you well know. You might recall that one of Aesop's Fables concerns an eagle who is not too careful about where he lets his feathers fall during his lofty flights. One day he swoops a little too close to the ground and a hunter shoots him with an arrow, and as the eagle dies he sees that the shaft of the arrow is feathered with one of his own plumes. As Aesop moralized, we often give our enemies the means of our own destruction.

In the face of plans now being made by outsiders for our future, the medical profession ought to be stronger and more unified than ever before in its history. Instead, we often appear to be falling apart. Not entirely because, to a great degree, non-medical men are the cause of this, but because of internal strife and disagreements. Gentlemen we are furnishing a great many feathers for the arrows of our enemies. We give them a feather every time a medical society member talks about withholding dues from his medical organizations. Or dropping membership because of disagreement with some program of the society. We give them a feather every time a group of physicians says it will quit the association because it does not like the new policy on abortions or compulsory attendance at hospital staff meetings or peer review.

Of all the problems that we have in medicine today one of the thorniest is comprehending the exact definition of peer review. The average physician in this country today considers the peer review mechanism as an FBI investigation or a detail ordered by the Internal Revenue Department on his income tax report and all one has to do is to turn to Webster's Collegiate Dictionary and the word peer means equal and we believe that our utilization of you committees, all committees of hospitals should be peer review committees composed of doctors, our equals, our peers. A rose would smell as sweet by any other name, we could call this committee A or Z, Alpha or Omega and it would be the same thing.

But I submit that on May 5, 1847, we had our first peer review committee organized. It was called the American Medical Association, it was organized for two purposes, (1) to clean up the mess we had in medical education and (2) to clobber the problem we had at this particular time in quackery. We have cleaned up some degree the mess we have had in education, but the problem in quackery is still with us and it is over a two-billion-dollar-a-year industry.

But we give our opponents a feather every time a single physician goes before a congressional committee and submits to a newspaper interview or goes on a TV talk show to condemn his colleagues and to disagree with them over legislative proposals.

For your knowledge, of the Committee of 100, 24 are MDs and 12 of these belong to the American Medical Association. That's quite a nice record. I think each one of us is entitled to his own opinion. I cannot agree with the 12 members of the Medical Association and their attitudes toward the philosophy of the Committee of 100 and the type of health legislation that it sponsors. Within our profession we find some

physicians that believe they are not a part of the profession because they do different types of work. Some educators are not concerned with the problems of the practicing physician. And, for the past three decades, the average practicing MD has shown very little interest in the educator. The administrator does not care what happens to the researcher and so forth. But those divisions, those opposing attitudes just give more strength to the hands of our enemies.

How can any physician believe that he will be exempt from what happens to his colleagues even though his work is different? We are all physicians and none of us can remain free unless all of us remain free. If government takes over and controls the practicing physician, it will not be long before it also takes over and controls the educator, the researcher, the administrator and all doctors, and medicine will become a public utility, just as the postal service, and you know what a mess that has been in for the last X-number of years.

If government tells one physician how to practice medicine and how much income he can earn, and what medicine he can prescribe, and government operates peer review and how the doctor and his colleagues will be organized, then it will not be long before it will tell the educator how he can teach and tell the researcher what he can look for and tell the administrator exactly how he can administrate. If we are going to maintain the integrity and freedom of our honored position, we must work together with unity and with strength. Dr. Annis today stated to you that he was listening to the young mayor of New York City on the radio as he drove over to the airport and the comments that the young mayor made with regard to 1972 and, that we were headed for absolute destruction unless certain things happened within a certain party and along a certain political philosophy; we have individuals in the medical profession who believe the same thing.

We will always have a medical profession. Civilization has to have a medical profession but we have disagreements in the medical profession and we must come to a consensus and the majority rule prevails and my plea has been and still will be for all doctors to belong to their medical societies—local, state and national—and participate. If doctors disagree, if we have disagreements among ourselves, let's settle these disagreements. Let's not go off to all points of the compass at the same time.

Then, too, we may have all the squabbles we want among ourselves, but when a gang comes in the backyard to pick on any of us, let's all get together and run the gang out. We can do that through the American Medical Association and organized medicine and I don't know of any other way. Because ours is the association of all of us. Whether we practice, teach, administer or research. Whatever our specialty, whatever our primary interest, we are physicians and we've got to have a strong medical organization, if the medical association is to have a choice in a debate over what kind of medical care people will get.

And now I would like to speak to one area of interest that I believe concerns all of us, and that is criticism of doctors by people in all segments of society, even our own colleagues, our lawmakers, whether they are at a national, state or local level, the news media—you name it. It has been said that baseball is a national pastime, but it has been my experience in the past three decades that taking potshots at the American Medical Association and the American doctor has succeeded baseball as a national pastime even though, in spite of the authoritative sports critics, Pittsburgh got 14 hits last night and barely got a one-run margin and won 4 to 3 over Baltimore, leaving 13 men on base. Baseball is pretty popular right now and will be through either Saturday or Sunday; and I am sure that after the season closes we can expect a little bit more in the criticism of the medical profession in our press. Ours is year-round, baseball is only six months out of the year.

What has been our track record, that of the medical profession? Dr. Annis reviewed it for you today and did it very beautifully. The contributions that American medicine has made. Has health in America been the fastest failing business that we've had? That, to me, is one of the most ridiculous remarks I have ever seen or heard. I think the sophistication of American medicine in the past 10 years and 20 years and 30 years has improved to the point where there is no nation on the face of the earth that can compare with the character of medical care that the American people in general get. One of the things that concerns me quite a bit is the fact that we have so much publicity. In a TV interview a few moments before I walked in, the main thrust of the question was: What are American Medical Association and the American doctor doing for the poor people of this country and the people who live in the inner city? So we answered these questions.

But does anyone ask you about the satisfied people that we have in America, the people who are satisfied with their medical care, their hospital care, that do not complain about health bills or medical bills? For your information, the American physician last year received in his fees from the cradle to the grave and including the grave, 7 billion, 3 hundred and seventy million dollars. The American people spent 25% more for booze and its products than it did for all forms of medical care and I don't see any congressional investigation into the usage of booze or to the prices of booze. And the American people spent 20% more on tobacco and its products last year than it did on all forms of payments to doctors from the cradle to the grave but I have yet to see anything about the tobacco industry. It seems to be pretty well protected.

We have been criticized, we have been maligned, but let me tell you this. Ours is a great profession, its a noble profession. Our main business now "is not to see what lies dimly at a distance but to do what lies clearly at hand." Thus spoke the seventh Earl of Carlisle over a century ago and these words were quoted by Sir William Osler in an address to Princeton University students on April 23, 1911 and I think Sir William was one of the greatest men we've ever had in medicine. This planet with its documented inhabitants of over 6,000 years has had its problems, its periods of prosperity and progress, its pitiful programs promulgated by power politicians, pitifully playing on the public. We are enmeshed and entrapped in a gigantic wave of a socialistic society of change and, in spite of the traditions of morality for which our founding forefathers so faithfully fought, fate seems to fight back in a fanatical fashion, rebelling against the very nucleus of a civilization which has so much to offer but which a perplexed public pathetically ponders as a panacea for all present and potential problems.

Let's set the stage now. The time the critical session of the American Medical Association in 1965. The place, Philadelphia, the city of Brotherly Love; the cast of characters at the meeting in '65, the officers and members of the Board of Trustees of the American Medical Association and the comparable components of the Pennsylvania Medical Society. The last speaker on the program, Mr. Lester Perry and his comments (and these were spontaneous comments); for 32 long years I have worked with doctors in this state and I have been your executive secretary and, as a layman, I am firmly convinced there are more of God's noblemen in the practice of medicine than in any other vocation, even including the ministry. What a

tremendous tribute this was to men of medicine! There has been no better tribute that I have heard in all my lifetime than this which was paid by an executive secretary of 32 years standing. We are riding a crest of medical greatness from a scientific standpoint and with it we need the greatness of dedicated men and women in medicine. The greatness reflected in the kindness and understanding of a doctor toward his patient. But as we race scientifically forward let us never discard the essence of the healing art. There is an aphorism from France which says of the medical mission: "To cure seldom, to help sometimes, to comfort always." We can update that now to say: "To cure often, to help frequently," but we cannot and should not change that last part "to comfort always." This to me is the very nucleus and the core of the practice of medicine, the doctor-patient relationship.

Let us not allow the few followers of Hippocrates who have failed to grasp the magnificent profession to spoil a noble calling. As you know, George Orwell said all men are equal but some are more equal than others. I might paraphrase that by saying that all physicians with MD degrees are equal in a scientific fashion but some practice only the scientific aspect of medicine and have yet to become permeated with the practice of the art of medicine, a characteristic which requires the milk of human kindness associated with integrity, honesty, devotion and dedication.

To those of you in medicine, may I remind you that when each of us comes to the end of a trail there is nothing we can take with us into the great beyond, but what wonderful treasures, what wonderful memories, what wonderful contributions we can make to our friends, our patients and society in general! So let each of us have a track record, that at the sunset of our lives we might say as St. Paul said: "I have fought a good fight, I have kept the faith, I have followed the course." My own personal philosophy of life and I believe, too, it must be yours, because you are doctors, is expressed in the text of a little known French philosopher and this was printed in the London Spectator, a weekly London newspaper, in 1792. "I shall pass through this life but once. If, therefore, there be any favor I can show or any good thing I can do, let me do it now, let me not defer nor neglect it, for I shall not pass this way again." Gentlemen, this I believe is the philosophy of each of you. May it be your track record. Thank you so much.

Reports of Officers

Executive Secretary

HOUSE ACTION: Approved. Referred to Board of Trustees for implementation.

As provided in the Constitution and Bylaws, the executive secretary is to make an annual report to the House of Delegates with, among other things, the actions taken by the previous House and disposition of those actions. Accordingly, herewith is the report of the resolutions adopted by the 1970 House of Delegates and their disposition.

Resolutions:

70-1 Which amended the Constitution and Bylaws to delete the mandatory Orientation Program. The action of the 1970 House had the effect of making this change in the Constitution and Bylaws and such change was recorded in the Constitution and Bylaws of the 1971 issue.

70-3 Calling for a study of the development of a Relative Value Schedule. This was referred to the Board of Trustees, who, in turn, referred it to the Commission on Medical Economics and Insurance, and their action is reported in their annual report to the House of Delegates of 1971.

70-4 Study and the appointment of a committee for the purpose of a fee-negotiating mechanism. The Board of Trustees referred this to the Commission on Medical Economics and Insurance and to the Commission on Governmental Medical Services and their action is reported in the annual report of these commissions to this House of Delegates.

70-8 Concerning insurance coverage for home health care. Was referred back to the Commission on Aging for further study and clarification as to implementation. No further action has been taken.

70-10 Calling for legislation to establish medical liability limits. Was referred to the Commission on Legislation. While this was studied, no definite solution by legislative route was found feasible; therefore, no legislation on this subject was introduced.

70-12 Support of Indiana Plan for Medical Education. This was referred to the Commission on Legislation, which did support the Plan, which was adopted by the state legislature.

70-13 Physical examination of school employees. This was referred to the Commission on Public Health and their action is reported to this House of Delegates in their annual report.

70-14 Support of Governor's Commission on Medical Education. Plan was referred to the Commission on Medical Education, who did support the proposal, and it became law.

70-15 Regarding semi-annual Meetings of the House of Delegates. Was referred to the Board of Trustees who, in turn, requested Dr. Wilhelmus, Chairman of the Finance Committee, and the Executive Committee to report on the estimate of cost and such report has been made to the Board.

70-16 Calling for resolution to create a Medical Department in the Board of Corrections. Was referred to the Commission on Legislation and a bill was introduced into the legislature but failed to pass, as it has for the past several years.

70-17 Calling for the executive secretary to make an annual report of the disposition of the previous House actions. Was requested in the 1970 session of the House of Delegates and this report constitutes carrying out of this resolution.

70-18 Reporting of AMA delegates' positions on issues. Was referred to the AMA delegation.

70-19 Hoosier Teen Health Happening. Was referred to the Board of Trustees who discussed this with the president and, inasmuch as facilities were not available for a repeat of this event during the year 1971, it was decided not to hold such a session at this time.

70-20 Licensing of medical assistants. This was referred to the Commission on Medical Education and Licensure who prepared a bill which was introduced in the 1971 session of the legislature and then withdrawn because of the opposition to such a bill at this time. Further details may be found in the annual report of the Commission on Medical Education and Licensure.

70-21 Dealing with inequities in dues payments. This resolution had the effect of amending the Bylaws to provide that physicians becoming a member for the first time after July 1st pay only half dues. Was adopted, and the resolution as written constituted a change in the Bylaws effective January 1, 1971.

70-22 Calling for a poll of the membership on abortion. While rejected by the House as written, it was referred to the Board of Trustees for their consideration on conducting a straw vote on liberalizing abortion laws and the AMA policy on abortion. Such a survey was accomplished with 59.6% of those replying saying liberalize; 36% said no; .004% no opinion. The question as to whether the membership agreed with the AMA position on abortion, 66.2% said yes; 27% said no; and .068% no opinion. The number of doctors replying to the poll was 49.5% of the membership.

70-23 Financing of renal dialysis program. This was referred to the Commission on Legislation. Such a bill was introduced in the 1971 state legislature and became a law.

70-24 Standards of non-medical drugs. This matter was referred to the Commission on Public Health and they deal with their disposition of this resolution in their annual report to this House.

70-28 Endorsement of Indiana Plan. This was referred to the Commission on Medical Education and Licensure and the report on this resolution is contained in their report to this House of Delegates.

70-29 Dealing with hazards of glass doors. Was referred to the Commission on Legislation to draft a bill on this subject. It was introduced and died in committee, but the Administrative Building Council has assured us that they will write measures concerning this hazard.

70-30 Uniform Ambulance Code. This was referred to the Commission on Legislation and a bill was drafted by the Board of Health on this subject and was introduced in the 1971 session of this legislature but the bill failed to pass, reasons being given were five million dollars appropriation to operate; and the objection of funeral directors and volunteer fire departments who operate ambulance services.

70-31 The Indiana Plan, calling for the endorsement of the plan. This was done and successfully passed the 1971 State Legislature.

70-32 Dealing with foreign medical graduates. This resolution was referred to the trustees who, in turn, referred it to the Commission on Legislation and drafted a bill, known as House Bill 1260, which was introduced in the 1971 General Assembly and became law.

70-34 Health certificates for re-licensing of certain individuals. Referred to the Commission on Legislation and no action was taken.

70-35 Calling for defining blood as a service rather than a sale. Was referred to the Commission on Legislation. A bill was drafted to provide blood as a service but in addition human organs and transplants were also defined as a service and not as a sale. The bill was introduced in the 1971 General Assembly and became law.

70-36 Calling for legislation on blood transfusions. This was also referred to the Commission on Legislation and made a part of the bill described in resolution 70-35 and became law.

70-38 and 70-39 Were combined by the House to adopt a substitute resolution calling on the Commission on Public Health and Commission on Legislation to pursue the matter of environmental pollutants. Referred to the Commission on Legislation, who devoted almost two months' discussion with members of the legislature and other interested parties on this subject. A Bill was drafted and introduced in the 1971 session but only a watered down version was adopted.

Membership

Last year your secretary reported on membership matters, pointing out that the gain for the period from July 31, 1969, to July 31, 1970, showed only a net increase of five. Thinking you might be interested in a 10 year comparative report, in 1960 there was a total of 4,620 physicians with 4,309 of them being members of the Indiana State Medical Association. As of 1970 there are 5,274 physicians listed as being in Indiana, of whom 4,505 were members of the association. Doctors engaged in patient care in 1960 totaled 4,228 and 4,638 in 1970. These figures are broken down as follows: Office based practice: 3,624 in 1960 against 3,909 in 1970. General practice: in 1960; 1,764, and, in 1970, 1,558. Medical specialties show 456 in 1960 and 584 in 1970. Surgical specialties: 1,056 in 1960 and 1,059 in 1970. Other specialties: 366 in 1960 and 708 in 1970. Hospital based practice: 586 in 1960 and 729 in 1970. Full time physician staff: 206 in 1960 and 236 in 1970. Other professional activities (which includes faculty, research, etc.) showed 186 in 1960 and 346 in 1970. Inactive: 206 in 1960 and 286 in 1970. On the basis of these figures, in 1960 93.27% of all doctors in the state of Indiana were members of the Indiana State Medical Association and in 1970, of the total number of physicians, 85.42% were members of the association.

It is probably time that perhaps county medical societies might consider reviewing the total number of physicians in their county and making a strenuous effort to take into membership those who are eligible and desirable. The Field Service of the association will be happy to assist county societies in this effort, if the county societies desire to avail themselves of their services.

The Executive Committee and the Board of Trustees have both had a busy and eventful year, particularly with the rapid change taking place in third party medicine. I would urge all members to read the reports very carefully.

CHAMPUS

The association has concluded its fourteenth year as fiscal administrator for the CHAMPUS program (Civilian Health and Medical Program of the Uniformed Services in Indiana). The operation continues to grow at an amazing volume and has reached a multi-million dollar operation. During the year of 1970 $1,384,353.05 was paid for this program in the state of Indiana. Compensation to physicians for professional services is made in the concept of usual and customary fees under medical peer review control. Federal officials have cited the Indiana operation as a model throughout the nation. A very small percentage of the claims received today are such that they are reviewed by the five-member review committee. In January 1971 the Department of Defense severed the program from HEW, inasmuch as the usual and customary fee administration and payment is made solely on profiles of charges by Indiana physicians. We are not expected to hold the 75th percentile as are other government programs in operation in this state.

Field Service

Following the close of the 1970 annual meeting, the three members of our Field Staff began an intensive campaign of visiting members of the 1971 state legislature in an effort to discuss with them many of the legislative matters in which the association had an interest. These men served as our representatives in the state legislature during the entire session, which precluded their work in the field with the county and district medical societies. However, they have worked diligently in attempting to visit each society in their respective districts at least once during the year.

Public Relations

Many times one has the opinion that the members of this association have little realization of the many daily activities carried out by the organization at the state level. Listed below are some of the areas in which the ISMA has, in a public relations sense, worked with people. This should give the membership an idea of activity in a variety of areas, which are separate from the projects and considerations of the Commissions and Committees, the Board of Trustees and the special committees which during the year worked in different project areas, all of which were staffed and coordinated through the Headquarters Office.

1. Provided information on Indiana law pertaining to foreign physician licensure in Indiana to individuals, universities and other states.
2. Information to students who wish to enter medical schools.
3. Provided filmstrip on Medicredit to societies.
4. Provided AMA with information on Commissions of ISMA.
5. Provided AMA News with material pertaining to ISMA and newspaper clips on a periodic basis.
6. Provided other Associations with information and materials on Medicredit.
7. Updated orientation kit for use by field staff in contacting new Indiana physicians.
8. Provided Hoosier Teen Health Happening video tapes to IU-PUI for use on their television network and for use on local cable television networks in Indiana.
9. Provide ISMA policy statements on smoking to various agencies.
10. Information on sex education for Conference on Human Sexuality.
11. Provided material and information on Physician's Assistants programs throughout the nation.
12. Continued to circulate HTHH films and tapes.
13. Provided information on abortion and abortion laws throughout the country.
14. Assisted out-of-state physicians in acquiring information on Indiana licensure laws.
15. Provided kits and materials on drugs and drug abuse to students, teachers and physicians.
16. Conducted 7th annual Journalism Awards program.
17. Provided materials to health teachers for development of health and safety files for teaching purposes.
18. Provided many materials on a variety of health subjects for research papers.
19. Provided local societies wishing to develop local public relations programs with materials to implement such programs.
20. Assisted societies in procuring films and speakers for meetings.
21. Assisted in promotion of district meetings.
22. Promoted all programs of the Association and the Annual Convention through appropriate flyers and publicity.
23. Provided news stories and background information to the news media on Association activities and policies.

Annual Convention

While the Annual Convention of the Indiana State Medical Association continues to be a highlight of the association activities, in which the matters that have been discussed by the various commissions and committees are picked as policy or are rejected, your secretary cannot help but sound a note of discouragement to the membership concerning our annual meetings. He has attended two meetings with the Pharmaceutical Manufacturers Association to discuss the lack of participation by pharmaceutical firms as exhibitors and advertisers in our state *Journal*. The trend, at this point, seems to be that the day of the exhibit hall during an annual meeting will be short lived. He has learned in the meetings with other states that many of them have completely done away with their commercial exhibits and have gone to a registration fee in order to defray the expense of the annual convention. In Indiana there has been for the past several years, as in all other states, a consistent drop in the number of exhibitors and in the amount of exhibit income. Whether this has stabilized remains to be seen, but if the trend continues, and if the association continues to propose an annual convention, other means may necessarily have to be found to finance this activity, whether it be by dues increase with a specific allocation made for the conduct of the annual convention, or whether it be done by a registration fee, hoping that this will meet the expense which annually runs better than $20,000 for payment of the speakers' honorarium and travel, rentals and other factors necessary to make the convention a success.

Physicians on AMA Councils and Committees

Neal E. Baxter, M.D.—Council on Occupational Health; Committee on Aerospace Medicine.

Roy H. Behnke, M.D.—Residency Review Committee in Internal Medicine

Norman R. Booher, M.D.—Council on Voluntary Health Agencies.

Wallace D. Buchanan, M.D.—Inter-Specialty Committee; Chairman, American College of Radiology.

Ross L. Egger, M.D.—Advisory Committee on Continuing Medical Education.

John S. Farquhar, M.D.—Chairman, Emergency Medical Services Committee.

Sprague H. Gardiner, M.D.—Committee on Health Care of the Poor; Chairman, Committee on Maternal and Child Care; Delegate, Section on Obstetrics and Gynecology.

Frank H. Green, M.D.—AMA Disability Insurance Claims Review; Committee on Private Practice.

Lester H. Hoyt, M.D.—Pathology Exhibit.

Charles A. Hunter, M.D.—Residency Review Committee of Obstetrics-Gynecology

Lall G. Montgomery, M.D.—Delegate, Section on Pathology

Myron H. Nourse, M.D.—Alternate Delegate, Section on Urology; Residency Review Committee for Urology.

Guy A. Owsley, M.D.—Chairman, Council on Medical Service, Liaison Representative Blue Shield Board of Directors.

Frank B. Ramsey, M.D.—President, State Medical Journal Advertising Bureau.

Lowell H. Steen, M.D.—Committee on Community Health Care.

Donald E. Wood, M.D.—AMA Board of Trustees.

Election of Secretary to Office in Forum for Medical Affairs

Your secretary was again elected Secretary-Treasurer for the 18th consecutive year for the Forum for Medical Affairs sponsored by the Presidents and Officers of State Medical Societies. This group conducts an annual meeting immediately preceding the opening session of the annual AMA House of Delegates meeting and is the largest attended single meeting held during the AMA annual session.

The Year Ahead

The association and its officers and staff are facing many new and challenging problems during the coming year. The amendment to the Constitution of the State of Indiana now providing for annual sessions of the state legislature raises a question as to whether we will continue to pull in our field staff from their other responsibilities in the field for this activity or whether we should consider staff expansion of a person wholly responsible for the legislative activity of this association. It is necessary that a person be on hand at all times during the legislature to watch for events, committee procedures, etc., that many times result in one not recognizing the original bill when finally passed. In addition to this, the individual legislator has little to say concerning bills that might be introduced. Heretofore the association came up with a proposal that its legal counsel write the

bill and then obtain members of the House or Senate to agree to sponsor such legislation. In 1972, for example, it is now necessary to file with the Legislative Council an outline of your bill and this is done in September. The Legislative Council then prepares the bill and pre-files it with the Speaker of the House or President Pro-Tem of the Senate, and sponsors of the bill are selected. It is anticipated that in 1971, by November 15, bills will be assigned to various committees of the House and Senate and committee meetings may be held on these issues although the legislature does not officially convene until January. Therefore, legislative activity becomes a 12-month, year around activity. It is the belief of your secretary that additional staff for this purpose will be needed with the field staff serving as back-up men in case of an emergency.

In the past year the association has seen the Society of Internal Medicine move its affairs into the headquarters building, using the facilities of the building for the meetings of their Board and other business affairs. The same is true of the Indiana Roentgen Society, as they are utilizing the facilities of the office for distribution of materials to the members, although they have not physically moved their records into the headquarters building.

The services of the association have been offered to county medical societies for the purpose of assisting them in sending out notices of meetings, distributing minutes of their society meetings and use of these facilities has greatly increased by the installation of the WATS line and a 24-hour recording service.

If these activities continue to show growth, there will be an urgent requirement for additional staff to handle these matters with dispatch.

Your secretary would envision that, with the many additional problems which are facing your organization today, with the amount of research required in providing the membership with similar information, with the increasing programs of the various commissions and committees, additional staff will be required if we are to keep abreast of this increased activity.

The headquarters building has continued to serve as a meeting place for all branches of medicine and for your commissions and committees as well as the Women's Auxiliary. The building you have, in my opinion, is a priceless asset which serves the association members very well.

In projecting thoughts for the future, your executive secretary pinpoints some of these areas as being the supply and demand imbalance of physicians, especially in the more rural areas of the state; the rising costs of health care and the continuing efforts by groups and individuals (in most cases other than the profession) to hasten the delivery of health care on a capitation basis, which, in essence, would provide physicians' services on a salary basis rather than a fee-for-service basis.

Other areas of concern are the increase in malpractice litigation, which has many serious implications for the physician and the patient in the delivery of health care; increasing chiropractic infiltration into the ranks of all legitimately recognized medical service ranks; and continuing medical education with the ever-increasing need for every physician to keep current.

Still another is the internal dissension and disunity which is causing considerable upheaval, perhaps less in Indiana than in other parts of the nation; nevertheless it is a growing problem which must be resolved if organized medicine is not to be splintered more than it is, and, I might add, much to the delight of its opponents.

These are problems which must be faced now. The day of leisurely thought and transition is gone forever. The ISMA must somehow streamline its procedures to act more quickly and responsively to the demands being made on it—not necessarily to acquiesce to these demands, but to present alternatives in the delivery of medical care which would confront third-party plans and would be controlled by the profession.

I have a firm belief that most of our members do not know of the many activities which are conducted by the ISMA and the American Medical Association to support them. There is an enormous communication blank between the individual member and his knowledge of the goals his state and national organizations are trying to achieve for him. The ISMA must improve this internal "blackout" in the interest of maintaining more unity and a more solid front against third-party interests who believe they know more about the practice of medicine and the delivery of health care than the physicians themselves do.

The ISMA membership must recognize that government and other organizations, in this period of rapid transmittal of ideas and the incorporation of those ideas into the changing patterns of everyday life, are "gearing up" every day to meet the challenges and enhance their own positions. The ISMA must recognize the necessity to do this, too, to compete effectively.

In addition to the need for more effective transmittal of facts and information to members, the Indiana State Medical Association should also recognize the need for a comprehensive ongoing public relations program utilizing all of the state's communications media on a regularly scheduled basis.

Involvement here would include the development of such materials as thirty and sixty second visual spot announcements for television, audio tapes and recordings for radio, advertising for the state's weeklies and daily newspapers, development of 15-minute and 30-minute features on Indiana State Medical Association programming and policies for radio and television, and the recognition that there are accompanying technical skills required in the production of such materials.

To launch such an approach to the public through the mass media would call for an outlay of approximately $25,000 in funds from the Association's annual budget to place such a program into operation, which heretofore has never been recognized, at least in the sense of a continuous annual effort. It would be in the best interest of the profession in Indiana. The entire format of such materials could be formulated under the guidance of the appropriate Commission of the Association and the Board of Trustees with the aid of staff, who are skilled, experienced and educated in the development of such materials.

The ISMA cannot afford at this time in history, to turn over to other organizations its own responsibilities in any one of the suggested problem areas which I have outlined.

ISMA must have the manpower, the knowledge and the capability of delivering effective programs and plans which can "block" publicity-seeking schemes in the delivery of health care as well as counter bureaucratically formulated medical care plans, which at this point in time have met with little "hard line" resistance or effective alternative and innovative suggestions for organized medicine.

As I enter my third decade of service to your association and the profession, I am acutely aware of the massive challenges confronting the private delivery system, and I am enthusiastic rather than discouraged or fearful over your forward thinking, determined proposals to meet these challenges. This is a time for leadership and courage which are characteristic of physicians. I hope that we of the staff may worthily contribute to your exercise of these qualities of your profession.

JAMES A. WAGGENER,
Executive Secretary

The Treasurer

HOUSE ACTION: Ordered filed for information.

Inasmuch as the audit for the fiscal year ending September 30, 1970, has been published in *The Journal*, I will not repeat it with this report. Instead my report

will deal with our financial status as of August 31, 1971.

The balance sheet reflects all funds except the Kitchen Fund, which has a bank balance of $5,700.09, the Ethel Gastineau Fund, with a balance of $24, and Dues Deposited in August to Be Distributed in September, with a balance of $1,051.

The net of income and expense for the General and *Journal* funds is running about as projected by the budget, and should be close to a break-even point for the fiscal year close.

The Executive Committee and the Board have regularly reviewed the financial statement and the investment account at each of their meetings and the Treasurer has followed the recommendations of these bodies by investing all available cash in short term bills or savings accounts in order to earn as much interest as possible.

The distribution of dues and the general ledger accounting for all funds has been successfully converted to a computer system during the year.

The certified audit for the fiscal year ending September 30, 1971, will not be concluded in time for this report but will be published in an issue of *The Journal* as soon as possible following its receipt.

LESTER H. HOYT, M.D., *Treasurer*

INDIANA STATE MEDICAL ASSOCIATION
Statement of Financial Condition at August 31, 1971

ASSETS	General Fund	Journal Fund	Building Fund	Medical Defense	Student Loan	TOTAL ALL FUNDS
Cash in banks—operating	$ 91,634.50	$ 3,663.71	$ 2,901.35	$ 8,175.35	$ 750.42	$107,125.33
Cash in banks—interest bearing	—	—	6,133.53	—	19,019.78	25,153.31
Short term treasury bills	198,061.25	—	—	—	—	198,061.25
Accounts receivable	5,771.59	6,093.48	—	201.87	103.38	12,170.32
Prepaid expenses	6,148.54	200.00	3,349.51	—	—	9,698.05
Long term investments	83,452.63	—	—	25,112.59	20,810.00	129,375.22
Property—less reserve for depreciation	17,903.92	—	417,643.74	—	—	435,547.66
Intra funds accounts receivable	16,417.53	—	62,759.24	1,881.58	—	81,058.35
Total Assets	419,389.96	9,957.19	492,787.37	35,371.39	40,683.58	998,189.49
LIABILITIES AND FUND BALANCES						
Accounts payable	12.00	—	510.99	—	—	522.99
Due to Champus	2,478.26	—	—	—	—	2,478.26
Payroll taxes accrued	86.69	—	—	—	—	86.69
Property taxes accrued	1,896.72	—	25,888.70	—	—	27,785.42
Dues payable AMERF	19,695.00	—	—	—	—	19,695.00
Non-interest-bearing notes	—	—	21,625.00	—	—	21,625.00
Advances AMA	10,033.71	—	—	—	—	10,033.71
Deferred dues income	125,141.52	—	—	—	—	125,141.52
Intra funds accounts payable	61,516.82	19,541.53	—	—	—	81,058.35
Total Liabilities	220,860.72	19,541.53	48,024.69	—	—	288,426.94
Fund balances October 1, 1970	187,559.21	—	443,883.28	31,788.63	40,000.00	703,231.12
Profit (Loss) 11 months	10,970.03	(9,584.34)	879.40	3,582.76	683.58	6,531.43
Fund Balances at 8/31/71	198,529.24	(9,584.34)	444,762.68	35,371.39	40,683.58	709,762.55
Total Liabilities and Fund Balances	419,389.96	9,957.19	492,787.37	35,371.39	40,683.58	998,189.49

Chairman of the Board

HOUSE ACTION: Ordered filed for information.

HIGHLIGHTS OF BOARD ACTIVITIES DURING 1970-71

1. Donald E. Wood, M.D., of Indianapolis, was endorsed by the Board of Trustees to run for the office of trustee of the American Medical Association. With this endorsement and the work of the Indiana delegation to the AMA, a successful campaign was conducted for Dr. Wood resulting in his election in June to this high office in the organizational structure of the AMA.
2. A study of the need for physician's assistants was launched by the Board under the direction of Peter R. Petrich, M.D., president-elect of Indiana State Medical Association. Object of the study was to determine need, whether physicians would utilize this type of service, and the type of training such a program should encompass.
3. Thirty resolutions and several additional reports of the Board of Trustees to the 1970 House of Delegates were referred to Commissions and Committees of the Association for report back to the Board with recommendations and/or implementation.
4. The Board rejected the request of Regional Medical Programs to endorse a comprehensive survey of each physician's practice in Indiana.
5. Representatives of the Board were sent to national meetings on foundations for medical care and peer review with instructions to report back to the Board on material and information from the meetings.
6. In view of 66% of the membership replying to a survey indicating interest in tours sponsored by the Association, the Board authorized the Executive Committee to study such tours and make recommendations to the Board concerning ones which would have possible interest for Indiana State Medical Association members. Automobile insurance coverage as well as auto leasing for Indiana State Medical Association members are also being investigated upon authorization of the Board.
7. The Board was kept abreast of Commission activities throughout the year through reports of their activities. Commissions investigated such matters as foundations, malpractice insurance, additional insurance programs for the membership and a broad variety of topics of current concern to the profession, as is reported in their statements to the House of Delegates for 1971.
8. Many fiscal matters were deliberated by the Board, including additional budgetary requests from Commissions, rental of the Association's Pennsylvania Street properties and current financial status of the Association.
9. Because of the quality of the efforts of Indiana Health Careers, Inc., in directing youth into the many such careers in Indiana, the Board authorized a $500 contribution to this group for 1971.
10. The Board-sponsored Ad Hoc Committee on Maternal and Child Care Problems (composed of practicing physicians) kept the Board abreast of its activities in the vital area of reducing infant mortality. The committee, with the help of supporting funds and a grant to the Indiana State Medical Association, has a staff working with the committee to assist in accomplishing its objectives.

11. The Board's Ad Hoc Committee on Relationships with Blue Shield had not, at the writing of this report, submitted a final report. The committee, which met three times in different sections of the state, had scheduled final meetings in June to conclude its investigations and subsequently make recommendations to the Board.

12. Every meeting of the Board heard discussions of national health insurance plans, Health Maintenance Organizations, Peer Review, Medicare and Medicaid. Periodic reports also were made by the dean of Indiana University School of Medicine and the state's commissioner of health.

13. The Board moved that the office of Speaker of the Indiana State Medical Association House of Delegates be studied by the Commission on Constitution and Bylaws.

14. A section in *The Journal* for scientific papers on medical specialty subjects was authorized by the Board of Trustees.

15. Proposed legislation on feed lots and environmental control was discussed by the Board. Features of the bills were studied and several recommendations were made for amending these bills. The Board adopted these recommendations. The Board was also kept abreast of other legislation being observed and supported or not supported by the Legislation Commission.

16. Dr. Scamahorn, president of the Association, reported to the Board on the successful Leadership Conference which had been held in the headquarters office and suggested that everyone who would in the future have an opportunity to take this course, do so.

17. The Board approved continuing the annual faculty—medical student—Indiana State Medical Association representative retreat. This retreat is held to exchange information between these three groups in the interest of keeping current with educational attitudes and recommendations by all three groups.

18. The Regional Medical Program's structure and activities were discussed throughout the year by the Board, with some members of the Board suggesting that the Indiana State Medical Association withdraw support of this group. The Board did vote to divorce itself from any relationship with Indiana RMP programs but then reconsidered the issue, pending the meeting of the executive committees of Indiana State Medical Association and RMP.

19. It was the recommendation of President Scamahorn that a second Hoosier Teen Health Happening not be held during 1971, because of the lack of available dates and adequate facilities in Indianapolis. He requested, however, that the budget for such an event be held in abeyance pending a time in the future when such a program might be held again.

20. In view of the approaching meeting of the Indiana General Assembly and its concern with many issues of health, including the matter of abortion, there was considerable discussion on the subject. A poll was taken of the membership to determine their attitudes in this area and, upon receipt of the results of the poll, the Board felt that as small a circulation of these results as possible should be made. This action was taken to avoid publicity on the results which might be misinterpreted by the public. It was generally accepted that the Indiana State Medical Association (1) tabulate and file the report with the various commissions and committees of the Association who were involved and interested, (2) that the State Association take no position on this controversial issue, and (3) make it clear to the individual members of the Association that they were free to lobby for or against such a bill in accord with their own desires.

21. The Board also moved that a resolution be prepared instructing the Board of Medical Education and Examination to encourage duly licensed physicians to practice in areas of greatest need. This action was taken in view of concerned lay groups in the licensing of foreign physicians.

22. Mr. Kilborn, president of Blue Shield, reported on parameters which were to be used for all Medicaid services. The parameters, in effect, were limitations on office calls, home visits, nursing home visits, injections, in-hospital medical visits, and other medical procedures under the Medicaid program. The Board approved these parameters contingent upon recommendations of the Commission on Medical Economics and Insurance. Following a study by that commission, the commission recommended rejection of the parameter policy, completely, and so forwarded their recommendations to the Board, which adopted the recommendations.

23. Blue Shield officials periodically reported to the Board throughout the year. Within the framework of these reports, it was pointed out that Blue Shield had increased from $47 million to $62 million in regular business during the year of 1969-70. The amount of their government volume increased from $32 million to $46 million during the same period.

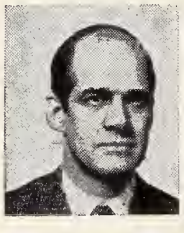
24. Concerning the health insurance program for Indiana State Medical Association membership, and based upon the request of several physicians to increase the amounts of benefits, rates were increased and the Board so moved that these rate increases be adopted. Professional health security plan was raised from $7,500 to $25,000 and the $15,000 lifetime maximum benefit was increased to $50,000.

25. AMA delegates were invited to meetings of the Board throughout the year to keep the Board informed of activities at the AMA level.

JOE DUKES, M.D. *Chairman*

First Trustee District

HOUSE ACTION: Ordered filed.



GILBERT M. WILHELMUS, M.D.,
Trustee

The annual meeting of the First District Medical Society was held May 6, 1971, at the Petroleum Club in Evansville. The meeting was attended by over 140 members and their wives. Dr. Joe Dukes, chairman of the Board of Trustees, and Dr. Malcolm Scamahorn, president of the Indiana State Medical Association, were in attendance. Mead Johnson & Company hosted our social hour preceding the dinner. Dr. Peter Olch from the National Historical Society of Washington, D.C., gave an entertaining talk on the life and history of Dr. Halstead. Dr. George W. Willison, former Blue Shield board member, and Dr. Willard Barnhart, present Blue Shield board member, reported to the group. Gilbert M. Wilhelmus, M.D., reported the past and present business activities of the Indiana State Medical Association—as well as local activities. Dr. Malcolm Scamahorn gave a summary report of the last legislature's activities which affected the Indiana State Medical Association. During the meeting the following officers were elected:

Raymond Burnikel, M.D., President
Bernard Rosenblatt, M.D., Vice-President
William Dye, M.D., Oakland City, Secretary-Treasurer

Gilbert M. Wilhelmus, M.D., Trustee, First District (re-elected)

The physicians in the First District have worked diligently this past year in many fields. In the spring of 1971 at the Blue Shield Seminar, Dr. Patrick Corcoran was on the panel to discuss the Vanderburgh County Foundation. Dr. George W. Willison was given a special plaque for his 12 years of service on the board of the Blue Shield.

Several physicians attended the Medical Student-Physician's Retreat at French Lick and their comments have been excellent in regard to this. They feel that the medical students of today are well informed. In their opinion, knowledge was transferred bilaterally.

The Vanderburgh County Medical Society, under the chairmanship of Dr. Bloss, had a sports seminar at which there was a total enrollment of over 100 coaches and physicians. Besides the local physicians on the panel there were other outstanding people from the sports world: Leslie Bodnar, M.D., University of Notre Dame; George Rapp, M.D., Indianapolis Capitols Football Team; W. D. Paul, M.D., University of Iowa; Mr. Kent Falb, Detroit Lions.

The Indiana State Medical Auxiliary, under the leadership of Mrs. Paul Clouse of Evansville, had their State House of Delegates Meeting in Evansville. Their program was a great success with many of the physicians' wives from over the entire state in attendance.

Medical education is in the forefront in our area as it has been in the past. Dr. Patrick Corcoran was appointed the Medical Education Director for the Indiana University program. Even though "Pat" is doing this part time, he has curtailed his large practice to give appropriate time and energy to this endeavor. I am certain the medical students will appreciate his strong efforts in medical education in Evansville. There has been an excellent program for their education planned for the future. Medical education in the First District is continuing with many weekly meetings, seminars, and CPC's. The Vanderburgh County Foundation, which has been in existence for approximately 10 years, is getting more stimulation because the Foundation idea is moving to the Mid-West.

The Trustee wishes to thank the many members of the District for their cooperation and activities in their local Medical Societies, and for their participation in the functions of the Indiana State Medical Association. It is a pleasure to see so many of the local physicians on various committees and commissions going to our state headquarters to attend the meetings.

GILBERT M. WILHELMUS, M.D., *Trustee*

Second Trustee District

HOUSE ACTION: Ordered filed.



JOSEPH E. DUKES, M.D., Trustee

The Second District Medical Association held its annual meeting at the Elks Country Club May 27, 1971.

Dr. Snyder, president of the Second District, opened the business session and gave a short message of welcome. A resolution by Dr. Chattin of Vincennes stated that mandated committees should be compensated at a rate of $50.00 per hour. This resolution was to stir thought and did not especially want action at this time.

Dr. J. S. Brown of Carlisle was given special commendation for his 49 years of service as secretary of the Second District. He was then elected for his fiftieth term.

Dr. Joe Dukes was again elected a director of Blue Shield.

Dr. Betty Dukes was re-elected alternate trustee of the Second District.

Dr. Scamahorn gave a short speech on legislation.

The feature speaker for the evening was Dr. Roger Newton of the Mead Johnson Research Center. His message concerned drug abuse.

This meeting was very well attended and was considered one of best district meetings in the past several years.

The next meeting will be hosted by Greene County.

JOSEPH E. DUKES, M.D., *Trustee*

Third Trustee District

HOUSE ACTION: Ordered filed.



ELI GOODMAN, M.D., Trustee

The Third District held its annual meeting at the Robert E. Lee Motel in New Albany, Indiana on April 7, 1971, with Floyd County Medical Society as the host group and Dr. Daniel Cannon presiding. The guest speakers were Dr. and Mrs. J.C. Willke of Cincinnati, Ohio. They discussed the Sex Education of Children and Adolescents from the viewpoint of a family physician and his nurse-wife. The headquarters of the Indiana State Medical Association was represented by Mr. Bob Amick who discussed the proposed Medical Legislation in the current session of the Indiana State Legislature.

In the election of officers, Dr. Daniel Cannon was re-elected president of the district and Dr. Charles McCalla of Paoli was re-elected secretary. Dr. Eli Goodman was elected trustee to replace the extremely capable Dr. Donald M. Kerr who had served two full terms and was not eligible for re-election.

Dr. Kerr gave a brief summary of his years of service as trustee.

There have not seemed to be any major intramural medical problems in the District during the current year. Your trustee apologizes for not having been able to attend county meetings in the District to this time but will make every effort to attend such meetings in the future.

The next District meeting will be held at the Marriott Inn in Clarksville on April 5, 1972. A program of "Gut" Issues is being planned under the leadership of Dr. Cannon. The various health care plans, peer review, and state and national aims and objectives will be dissected. I hope that as many as possible will attend this meeting.

ELI GOODMAN, M.D., *Trustee*

Fourth Trustee District

HOUSE ACTION: Ordered filed.



ROBERT M. REID, M.D., Trustee

As I submit this last of a series of singularly unexciting reports it would seem that after more than eight years in the role of Trustee I should have at least one or two significant comments. Unfortunately those things which occur to me now are observations previously and more effectively stated by my predecessors.

Generally, of course, one is concerned about the lack of interest manifest by ISMA membership. On my desk as I write this is a letter from the president-elect expressing concern that four of our several district representatives on various commissions have failed to attend *any* meetings during the year. These were individuals who had expressed willingness to work in their respective areas. Any trustee could

point to many other examples of indifference.

In considering the causes obviously one must look first to the leadership. Reflecting on my several years of observation, I consider ISMA to be directed, for the most part, by a capable, highly motivated group who give a surprisingly heavy chunk of themselves during their extended tenure to innovate and carry out programs which they consider to be in the best interest of the membership. Further, I believe that there is a steady improvement in the quality and dedication of these individuals from year to year.

How then do we fail? A number of possibilities would be considered. The lack of any real power over the membership dilutes the need for attention to the organization, the heavy involvement of the physician members in the pursuit of their own obligations and interests, and the much discussed individuality of physicians all certainly play a part. I think, however, another less tangible factor must be considered important. I refer to the increasing political sophistication of our organization. There is such sensitivity to the wishes of any expressed opposition to the various activities of ISMA that many promising efforts are abandoned almost before they have been fully considered. Such opposition is frequently from small but articulate groups of physicians who apparently feel vulnerable in some situations. My attention is, no doubt, directed to this problem as a result of some of my personal experiences. I am impressed by the number of times I have been told regarding one effort or another, "Bob, old boy, we believe in you and we understand what you are doing, but we just can't take the heat from the membership." I wonder if some greater effort to acquaint our physician colleagues with the background and possible promise of new and sometimes different approaches might not stimulate more interest and, hopefully, progress. I don't believe that the fact that I speak defensively in this matter seriously detracts from the validity of the observation. I don't use this space or take your time to plead or martyr a cause but simply to reflect that this "federal" type of political orientation may be one of the things that has become uninteresting about our leadership.

I would like to congratulate the Dearborn-Ohio County Medical Society on an unusually well conducted district meeting in May of this year. The accumulation of a significant district treasury, the fact that there was a three-man race for Trustee and the interest expressed at the meeting all offer hope for the future of the Fourth District. Finally I wish to offer my support and good wishes to my successor, Jack Shields.

ROBERT M. REID, M.D., *Trustee*

Fifth Trustee District

HOUSE ACTION: Ordered filed.



WILBERT McINTOSH, M.D.,
Trustee

Our meeting was held the 14th of May at the Terre Haute Country Club. In the afternoon there was a business meeting which many dignitaries attended, including the president-elect and the chairman of the Board.

We also discussed improving attendance and our approach to this, which I think is significant for our area, is that we have made a $10 dues for our district meeting, which includes dinner. We are going to try this and see if it does help attendance. Doctor Wakiem, Director of the Terre Haute Medical Education Foundation was the speaker for the evening.

The next meeting will be held May 24, 1972.

WILBERT McINTOSH, M.D., *Trustee*

Sixth Trustee District

HOUSE ACTION: Ordered filed.



STEPHEN D. SMITH, M.D.,
Trustee

This year the report will be short. At our annual meeting at Greenfield this year, we were quite short in participation, not only at the general meeting and dinner where John Pont spoke, but more so on the golf course. Those that did show up were mostly from Greenfield and Richmond with a few from Shelby County.

Dr. Mark Smith was elected president, Dr. John Moenning of Greenfield, vice president, and Dr. John Tower, Shelbyville, secretary-treasurer, for the coming year.

It was suggested that a resolution be placed in the works for this year's convention concerning the election of an assistant or alternate for each Blue Shield Board member being elected to ensure some continuity of the office and thought of purpose.

STEPHEN D. SMITH, M.D., *Trustee*

Seventh Trustee District

HOUSE ACTION: Ordered filed.



JAMES H. GOSMAN, M.D.,
Trustee

The president of the Marion County Medical Society, Dr. Donald E. Stephens, was elected president-elect of the Seventh District Medical Society at its annual meeting June 2 a the Martinsville Country Club. Dr. Stephens will succeed Dr. John M. Records of Franklin in 1972.

In other voting, Dr. Merrill M. Wesemann of Franklin was elected secretary-treasurer to succeed Dr. Stephens; Dr. John O. Butler, Indianapolis, was elected Seventh District trustee to succeed Dr. James H. Gosman of Indianapolis, who is candidate for president-elect of the Association, and Dr. Joseph F. Ferrara, Franklin, was elected alternate delegate to succeed Dr. Butler.

During the meeting, Dr. Ellery T. Drake of Martinsville, the outgoing President, complimented the Hendricks County Medical Society for its letter to the president of Blue Shield protesting the wording on some of its form letters mailed to patients, such as "fee not allowed." It was moved, and the motion carried, that the district society direct a letter to Blue Shield condemning the use of the statement "fee not allowed" and urging substitution of the phrase "not covered by . . . ."

After dinner, Dr. Raymond H. Murray of Indianapolis, director of the Regenstrief Institute and president of the Metropolitan Health Council, discussed "What's New in Health Delivery Systems."

At the conclusion of the meeting, Dr. Drake relinquished control of the meeting to Dr. Records who announced that the 1972 annual meeting of the Society will be held on Wednesday, June 14, 1972, at the country club in Franklin, and that Dr. Otis R. Bowen, Speaker of the Indiana House of Representatives, will be guest speaker.

JAMES H. GOSMAN, M.D., *Trustee*

Seventh Trustee District

HOUSE ACTION: Ordered filed.



DWIGHT W. SCHUSTER, M.D.,
Trustee

The Seventh District Medical Society held its annual meeting on June 2, 1971, at the Martinsville Country Club. There was a better than average turnout for the dinner, the business session and the scientific meeting. Dr. Ellery Drake presided. Guests included Dr. and Mrs. Malcolm O. Scamahorn, President of ISMA. Dr. Donald Stephens was elected president-elect and Dr. John Records began his term as president of the Seventh District. Dr. John Butler was elected trustee to succeed Dr. James H. Gosman, and Dr. Joseph F. Ferrara was elected alternate trustee to succeed Doctor Butler. Next year's annual meeting will be in early June 1972 at the Franklin Country Club.

Dr. Raymond Murray of Indianapolis was the after-dinner speaker. He made an excellent presentation of a complex subject, Federal Health Programs in Marion County.

On June 15, 1971, there was a general meeting of the Marion County Medical Society with a panel presentation on the subject of proposed and pending health service programs, including discussion of HMO's and Medical Society Foundations. More than 100 doctors, plus some hospital personnel, attended this meeting which was directed toward alerting physicians as to rapidly developing changes in the delivery of medical services.

The Seventh District Medical Society is proud to announce the candidacy of one of its outstanding members, Dr. James H. Gosman, for the office of president-elect of the Indiana Medical Association, subject to election at the annual meeting of the House of Delegates in October 1971.

DWIGHT W. SCHUSTER, M.D., *Trustee*

Eighth Trustee District

HOUSE ACTION: Ordered filed.



RICHARD INGRAM, M.D.,
Trustee

The 1971 annual meeting of the Eighth District Medical Society was held Wednesday, May 26, 1971, at the Portland Country Club. There was golf in the afternoon with several participants and prizes for the winners. In the early evening, a business meeting was held at which guests were present, including: Peter Petrich, M.D., and Mr. Howard Grindstaff of Indiana State Medical Association. The business consisted primarily of the election of officers. The officers elected for the 1971-72 year were: president, Franklin K. Beeler, M.D.; and secretary-treasurer, Edward R. Bush, M.D., both of Anderson.

The business meeting was concluded after the election of officers, and a pleasant dinner was then held at which the wives of the members of the district medical society were guests. Following dinner, the speaker, Dr. Campbell, of Indianapolis, gave a very interesting and informative talk on the subject of venous bypass grafts for coronary artery disease. It was enjoyed by all and there was much participation in discussion following the talk.

In the past year, in the eighth district, there have been many points of concern regarding organized medicine. However, the foremost matter for concern is the threatening approach of national health insurance or government medicine. From discussion throughout the district for the past year, it has become apparent that physicians in this district feel that it's time for organized medicine to adopt a philosophical stand on the issue of government medicine to which they may repair and be able to defend.

Doctors in general feel that as we have compromised with government and the forces of socialization, we have been piecemeal giving away the freedoms of both ourselves and our patients. It is my impression that the doctors of this district now feel that it is time to adopt a positive statement of policy at all levels of organized medicine which will inform physicians, the general public, and the federal government as well exactly what our philosophical position is, and the length to which we are willing to defend it.

I realize that this may sound like strong medicine at a time when much of the public doesn't have a very high opinion of medical organizations in general. However, it seems that we have tried all available compromise approaches without significant success. In fact, consistently losing ground in our fight against socialized medicine.

Therefore, it seems that the only logical stand to take at this time is a positive statement of policy to which physicians concerned with the private practice of medicine may repair and be able to defend.

RICHARD INGRAM, M.D., *Trustee*

Ninth Trustee District

HOUSE ACTION: Ordered filed.



WILLIAM M. SHOLTY, M.D.,
Trustee

My first year as trustee has been informative. Interest by the county medical societies in the Ninth District in ISMA is increasing as more M.D.s are becoming aware of the forces at work to destroy the freedom of medical practice as we have known.

The Ninth District Medical Society met at the Lafayette Country Club on June 3, 1971. The host county was Hamilton with Dr. R. Adrian Lanning, county president, presiding. The meeting was held in Lafayette because of its central location in an effort to attract a larger attendance.

Golf and skeet shooting were enjoyed by those participating.

The scientific session was held at 2:30 p.m. Twenty to twenty-five members attended. The business session was held following the scientific session. The minutes of the previous meeting were read and approved. Dr. Max N. Hoffman was elected alternate trustee.

Dr. Malcolm Scamahorn, president of ISMA, discussed the legislation of the past General Assembly.

Dr. Robert Hedgcock offered a resolution requesting the ISMA to disassociate itself from the AMA. The motion was defeated.

The evening dinner and program was attended by 86 doctors, wives and guests. The program consisted of a trio of Purdue University Glee Club members and an address by Dean Earl Butz on "Practical Ecology."

A meeting is planned for the delegates prior to the annual ISMA meeting to discuss resolutions that have been proposed so the delegates can present a more or less uniform front.

As Ninth District trustee, I want to thank my counties for their interest and cooperation. As trustee, I am aware of the tremendous struggle medicine must wage

in order not to become completely socialized.

WILLIAM M. SHOLTY, M.D., *Trustee*

Eleventh Trustee District

HOUSE ACTION: Ordered filed.



LOWELL J. HILLIS, M.D., Trustee

The meeting of the Eleventh Trustee Medical District was held on the third Wednesday in September 1970, at the Wabash Country Club. Dr. Lloyd Hill of Miami County was elected president; Dr. Fred Poehler of Wabash County was re-elected secretary-treasurer.

During the past year, the state president Dr. Malcolm O. Scamahorn visited the Huntington County Medical Society as a part of his so-called "whirlwind tour" of northeastern Indiana. The message that was brought by Dr. Scamahorn was well received by the members of the Huntington County Medical Society and this was deemed to be a highly successful and enthusiastic meeting.

The Cass County Medical Society sponsored a labor-organized medicine meeting in March 1971. This was a highly successful meeting presenting speakers for organized medicine and for the labor unions. This meeting was so well received in the community that it has since been repeated as a part of the functions of the Cass County Chamber of Commerce.

The 1971 meeting of the Eleventh Councilor District is scheduled at the Missisinewa Country Club at Peru on September 15.

This should be a great meeting. The committee has worked extremely hard and the highlight of the meeting is the speaker of the evening, Dr. Edward Annis, past president of the American Medical Association, from Miami, Fla.

Election for alternate trustee will be held at this meeting.

Otherwise, the attitude of the doctors in the Eleventh District has been "business as usual."

LOWELL J. HILLIS, M.D., *Trustee*

Twelfth Trustee District

HOUSE ACTION: Ordered filed.



WILLIAM R. CLARK, SR., M.D., Trustee

Our Annual Meeting was held May 19, 1971, at the Chamber of Commerce in Fort Wayne.

George Manning, M.D., president of the 12th District, presided. New Officers named were: George Manning, M.D., re-elected president; Frank Bryan, M.D., re-elected vice president; Brad Hughes, M.D., re-elected secretary-treasurer; and Walter Griest, M.D., elected alternate trustee.

The following guests were present: Thomas Terrell, M.D., AMA Alternate Delegate; Richard Ingram, M.D., Eighth District Trustee; Vince Santare, M.D., 10th District Trustee; Mr. John Walters, our field representative and Mr. Donald Van Dykes, vice president, Indiana Blue Shield.

Mr. Raymond Robillard, M.D., president of the Federation of Medical Specialists of the Province of Quebec, was the speaker of the evening. The subject of his talk was "Happenings of Organized Medicine versus State Medicine in the Province of Quebec." The information given by this well-informed, articulate speaker was well received and greatly appreciated.

The chief happening of the District was the tour of five of my eight counties, set up for Dr. Scamahorn and myself by Mr. John Walters, our field representative. The various counties held special breakfast, luncheon or evening meetings. This turned out very successfully, proven by the fine attendance of the physicians. There were only three absentees of the entire five-county membership. It was so well received that I have been asked by the county officers to duplicate the tour next year.

During the past year I have written synopsis reports of the proceedings of the State Board of Trustees which were mailed to the various county secretaries, who in turn, posted them on the hospital bulletin boards. This will be continued because of the great interest shown in this method of quickly getting to the membership the information of the proceedings of the Board of Trustees. I will also continue to make personal reports to the monthly meetings of the Ft. Wayne Medical Society board of trustees.

I want to thank the District officers and the physicians that are working on the various state commissions and committees. You are doing a yeoman job and I am very proud of your efforts in behalf of the District and organized medicine. I want to thank Dr. Fred Schoen, my retiring alternate. He has done an excellent job supporting me.

I, as your Trustee, along with the officers, and the new alternate trustee, Dr. Walter Griest, look forward to meeting these changing times of organized medicine. I will sincerely dedicate my efforts, not only towards the best interest of the District and ISMA, but also towards the national change in health services so that the physician will never lose his identity in patient care.

WILLIAM R. CLARK, SR., M.D., *Trustee*

Thirteenth Trustee District

HOUSE ACTION: Ordered filed.



OTIS R. BOWEN, M.D., Trustee

The 13th District Medical Society of the Indiana State Medical Association held its annual meeting on September 3, 1970, at the Elkhart Hotel. Although the attendance — as seems usual for afternoon district meetings — was rather slim, the quality of the program was excellent. Mr. Jack Holiday, Manager of Elkhart Clinic, Credentials Chairman of the American Association of Medical Clinics, spoke on "Foundation Medical Problems Anticipated in Elkhart County." This was followed by a talk on Blue Shield of Indiana's proposed Foundation Plan medical practice by Mr. Herbert Dixon. The last speaker of the afternoon presented a very interesting paper. He was Dr. Sam Packer, medical director of Ohio Permanente Medical Group of Cleveland. He spoke on experiences of physicians in foundation practice in the midwest — pros and cons. This was followed by a lively panel discussion, with questions from the floor.

The business meeting was then conducted, with 25 members present. The officers elected for 1971 were: George Haley, M.D. South Bend, president; Frank McGue, M.D. Michigan City, president-elect;

John Hildebrand, Jr., M.D. South Bend, secretary-treasurer; Beach Gattman, M.D., Elkhart, alternate trustee.

We were privileged to have the President-elect of the ISMA, Dr. Malcolm Scamahorn, present. He gave a few remarks.

The dues for the district were discussed, and it was decided to leave them at $2.00 per physician per year.

A delightful dinner-meeting was then held in the Banquet Room of the Elkhart Hotel, and the speaker of the evening was Mr. Donald M. Newman, a pharmacist of Mishawaka who was at that time a candidate for Congress from the third Congressional District.

A hospitality room was available for the wives of the physicians during the afternoon. The hospitality room was maintained up until the dinner hour and was sponsored by the Wayne Pharmacal Supply Company.

Much time of the members of the 13th District was consumed in plans and preparation for the Indiana State Medical Association meeting in South Bend in October 1970.

At the present time, plans are being discussed for the September meeting of the 13th District Medical Society.

OTIS R. BOWEN, M.D., *Trustee*

Editor of The Journal

HOUSE ACTION: Ordered filed.

The financial accounts for the fiscal year show promise of running close to the budget. National advertising has been a few percentage points above that of last year. On the expense side there have been a few increases for such items as postage and clerical help.

The May issue this year, which was devoted almost entirely to the problems of drug abuse, has proven to be most popular and helpful. Special reprints of the drug articles, including the reference lists of literature on the subject, and bound with the prize-winning drug-poster cover, have been printed and distributed to all high schools and junior high schools in the state.

We have had an adequate number of good scientific articles. Of special interest was the symposium on the kidney transplantation team and its work at Indiana University.

The Journal's function as historian for the Association was represented by outstanding presentations on the history of medicine and medical education in Evansville and a personal account of the life and times of Dr. William Hutchings in Madison, written by a professional science writer, Mrs. Elisabeth Z. Kelemen. The historical series will be continued next year by a special issue on the early days of medicine in Vincennes.

Frank B. Ramsey, M.D.
Editor

Delegates to AMA

HOUSE ACTION: Ordered filed.

A concerted effort by the Indiana State Medical Association delegates and alternate delegates to the American Medical Association's 120th Annual Convention in Atlantic City, June 20 through 24, placed Dr. Donald E. Wood, Indianapolis, in an AMA Board of Trustees slot.

Doctor Wood, who was at that time serving as ISMA delegate, filled the vacancy of L. O. Simenstead, M.D., who was ineligible for re-election. His bid for the Board went unopposed.

Guy A. Owsley, M.D., Hartford City, was re-elected to the Council on Medical Service.

The ISMA delegation, working tirelessly, began each day with a 7 a.m. breakfast meeting, caucused several times during the week and was in constant contact with other delegations concerning the reports of AMA officers and the Board of Trustees, reports of the various councils and the 98 resolutions submitted by state societies throughout the nation. Altogether there were 158 items of business.

These were thoroughly reviewed by the delegation and decisions were made as to support or nonsupport, with each member of the delegation receiving reference committee and other assignments.

The Indiana delegation introduced three resolutions; one dealing with physician's liability for injuries resulting from substitution of drug products; another with release of information on Medicare and a third on substitution of medications other than that specified in physician's prescriptions.

The resolve on the liability resolution stated:

> "That the American Medical Association advise physicians that the proposed Drug Product Selection Authorization Agreement, proposed by the American Pharmaceutical Association, designed to over-rule existing laws against drug product substitution, will in no sense relieve physicians of their legal and ethical responsibilities to their patients; but rather that the signing of such agreements may complicate the physician's professional liability in the event that pharmacists defend themselves against patient injury suits by arguing that they were acting in accord with an agreement signed by the prescriber."

The resolution and the other resolution, which also warned of drug substitution efforts by the American Pharmaceutical Association, were adopted by the AMA House of Delegates.

The Medicare resolution was critical of the Department of Health, Education, and Welfare's and the Social Security Administration's "blatant infringement" on the physician's right to make medical decisions.

The resolution pointed out that these departments were becoming more and more critical of moneys expended for medical care and less concerned with the actual medical needs of each patient and the true costs of this care.

Resolution asked that this information be imparted to the public through the nation's media. Reaction of the reference committee was not to adopt the resolution but in so doing the committee expressed the sentiment that the AMA was already doing a "creditable job" in this area.

Delegates attending the meeting from Indiana were Eugene F. Senseny, M.D., Fort Wayne, chairman of the delegation; Jack E. Shields, M.D., Brownstown; John S. Farquhar, Jr., M.D., Fort Wayne; Doctor Wood; and Frank H. Green, M.D., Rushville.

Alternate delegates attending included Patrick J. V. Corcoran, M.D., Evansville; Thomas C. Tyrrell, M.D., Hammond; James A. Harshman, M.D., Kokomo, Eugene S. Rifner, M.D., Van Buren and Kenneth O Neumann, M.D., Lafayette.

Assisting the delegation were Sprague Gardiner, M.D., Indianapolis, delegate from the AMA Section on Obstetrics and Gynecology; Lall G. Montgomery. M.D., delegate from the Section on Pathology and Physiology, and Myron H. Nourse, delegate from the Section on Urology.

In attendance for the Convention, too, were Malcolm O. Scamahorn, M.D., Pittsboro, president of ISMA; Peter R. Petrich, M.D., Attica, president-elect; Joe Dukes, M.D., Dugger, chairman of the Board; and Lester Hoyt, M.D., Indianapolis, treasurer.

In addition to studying, discussing in committee and acting on the items of business, the House of Delegates heard a stirring speech by the President of the United States as well as outlines of the future as seen by both outgoing and incoming Association presidents.

Meeting for a total of 13 hours and 53 minutes, the House acted on six special reports, 31 reports from the Board of Trustees, two from the Council on Constitution and Bylaws, four from the Council on Medical Education, eight from the Council on Medical Service, two from the Judicial Council, and one from the Council on Long Range Planning and Development, and 104 resolutions.

Elections

Charles A. (Carl) Hoffman, West Virginia, was chosen President-Elect of the AMA. Others elected or re-elected to Association positions were:

Vice President: Ralph C. Teall, California.

Speaker of the House: Russell B. Roth, Pennsylvania (re-elected).

Vice Speaker of the House: J. Frank Walker, Georgia (re-elected).

Trustees: John M. Chenault, Alabama (re-elected); Raymond T. Holden, Washington, D.C. (re-elected); John R. Kernodle, North Carolina (re-elected); Robert B. Hunter, Washington (to fill the unexpired term of Burtis E. Montgomery); and Jere W. Annis, Florida (succeeding Charles A. Hoffman).

Judicial Council: Henry I. Fineberg, New York (succeeding Renato J. Azzari).

Council on Constitution and Bylaws: Carroll L. Witten, Kentucky (re-elected); and John H. Burkhart, Tennessee (to fill the vacancy left by Robert Hunter's election to the Board).

Council on Medical Education: James W. Haviland, Washington (re-elected); and Bernard J. Pisani, New York (re-elected).

Council on Medical Service: C. Willard Camalier, Jr., Washington, D.C. (filling the vacancy of Charles J. Ashworth who was ineligible for re-election).

Address by Richard M. Nixon
President of the United States

President Nixon began with some general statements based on Disraeli's comment that "The health of the people is really the foundation upon which all their happiness and all their powers as a state depend," pointing out that "I am happy for this opportunity to salute this profession which has contributed so much to the health of the American people and to the strength of this nation."

He talked about the current debate on national health insurance, emphasizing that "I believe that the most expensive plan that has been offered—a plan for nationalized, compulsory health insurance—is the plan that would actually do the most to hurt health care in this nation."

Such a plan, the president said, "would exact a very high price from our people in terms of dollars and cents. But it would exact an even higher price in terms of the quality of American medicine."

Mr. Nixon emphasized that America's health care system needs reform. But he added that "We can never improve our country's medical system by working against our country's medical profession. No system of health care will ever work unless the doctors of the nation make it work. So let us work together," he said, "for a system—a system that will continue to provide for choice, that will continue to provide for quality and one that will at the same time deal with the pressing problems of costs in an effective way that will not destroy quality."

The bulk of the president's 34-minute talk, which was punctuated several times by applause, was a challenge to America's physicians to assume leadership in curing and preventing drug abuse. That problem, he said, "is America's public enemy number one. It afflicts the rich and the poor, the blacks and the white, the servicemen and the civilians, and the ghettos and the suburbs. It spreads like a plague throughout our society. It erodes our nation's strength. It destroys our nation's spirit. And worst of all, it undermines our nation's future.

"The best way to end drug abuse is to prevent it, and America's doctors are the indispensable front-line soldiers for success in this all-important battle. No one, believe me, no one can have more effect when he or she speaks out than a doctor on this issue of drug abuse. You speak with greater authority, because you speak about the power of drugs to save life—but also the power to destroy it.

"Rather than preach moralistically about the sinfulness of drugs, you can teach realistically about their physical and psychological impact."

The president finished this major portion of his speech by saying, "The AMA can once again render outstanding service at a point of critical need by helping to develop what I would like to call Project USA—a project which would marshal the tremendous energy, the brains, the dynamism, the leadership—the leadership—of the doctors of this country in an all-out battle against drug abuse."

After some remarks about the need for physicians to be more active in politics and community leadership, President Nixon closed with these words: "The health of America is in your hands, and by its health I speak not just of its physical health—but its mental health, its moral health, its character. Meet that challenge."

AMA Response

Directly and immediately accepting the president's challenge, the Board of Trustees came before the House with its Report EE, which the House adopted. The report points out that "In respect to the urgent problems of drug abuse, the Council on Mental Health and its Committee on Alcoholism and Drug Dependence have already given support to the President's announcement of the establishment of a Special Action Office of Drug Abuse Prevention within the Executive Office and to his proposal to strengthen resources and programs for treatment and rehabilitation of drug-dependent persons."

The report recommended and the House adopted as policy that the AMA "strengthen and expand its program to combat drug dependence with particular attention to prevention, identification, treatment, rehabilitation and research and that state and local medical societies be urged to give priority to the implementation of this program at the community level throughout the nation." The House also called upon "individual physicians—whether in practice, research, teaching or administration—to give special attention to problems of drug abuse and to volunteer their efforts to community programs."

Final Report to the House:
Walter C. Bornemeier,
President of the AMA

In describing his "Blueprint for the Future," Dr. Bornemeier pointed out that of three principal ingredients of medical care—cost, quality and availability—"availability is on the front burner. People are more concerned about getting medical care when they need it," he said, "than they are about its cost or its quality. The question never has been 'Is there a good doctor in the house?' or 'Is there a cheap doctor in the house?' The question has always been 'Is there a doctor in the house?'"

Along with increasing the number of physicians being produced by the nation's medical schools, Dr. Bornemeier said that "group practice appears to be the answer" to availability. "Groups can be either fee-for-service or have a prepaid package arrangement. They could be a combination of the two.

"When we eventually have a private practice group in every neighborhood," he said, "we will have come full circle, from a doctor over every drug store to a multispecialty group facility in every population center. It is my firm conviction that if we bring comprehensive medical care back into the population centers, the neighborhoods, and have medical care available 24 hours a day, seven days a week, the people will tell congress that the present system does not need to be restructured."

Dr. Bornemeier also pointed out that expanding group practice centers will lead to a strong come-back for the family physician, who will best be able to give complete care to the whole patient. "Group practice," the president said in closing his final report, "has been on the increase and all indices point to accelerated devel-

opment of this type of practice. Along with this, a movement of group practice to the population centers is inevitable. Competition between groups will encourage distribution to residential areas. All of this adds up to availability, today's most important ingredient of health care."

Inaugural Address:
Wesley W. Hall, President of the AMA

In his inaugural address, the AMA's 126th president began with a brief history of medicine as an art and science. "What was the state of medicine for some 6,000 years?" he asked. "Compassion, hope and the patient's confidence in the physician were the foundation stones upon which medicine rested for centuries. As an exact science, medicine had its beginning less than a century ago, when Robert Koch discovered the tuberculosis bacillus in 1882."

He traced the growth of medicine to the present time and then detailed some of the profession's more pressing problems of today, including the state of medical education, the need for more manpower, care for the poor, rural health, and the like. He pointed out, however, that often too much emphasis is put on problems and not enough on achievements. "We need not agonize that we have not done enough," he said. "We should trumpet our successes while we strive all the harder in those areas where we have not yet attained perfection. To assure that, in a rapidly changing world, the AMA will be able to pursue its historic goals," Dr. Hall offered suggestions for consideration by the House.

The first was that the Association have a constitutional convention to "streamline our governing process to suit the needs and pace of the 20th century physicians and its people;" to "combine overlapping functions within our organization;" and "enfranchise those whose voices we should hear."

He listed major changes made in past years by the AMA, but pointed out that "This year, one or two changes will not be enough."

Some of his suggestions were "at least one additional meeting day" for the House to conduct its business; re-examination of "the aims and duties of our 100-plus councils, committees and commisssions;" moving "through our state organizations to bring a greater number of young, able and productive physicians into our Association;" setting "a limit upon the number of terms delegates can serve in this House;" and rescinding "a number of outdated and long-ignored resolutions (that) remain on our books as policy statements.

Dr. Hall urged the Woman's Auxiliary to undertake new and increased activities in "encouraging prenatal care for the expectant mother, especially in rural areas and in areas where low-income families are concentrated;" and in "helping to combat problems of teenage drug abuse and addiction."

Referring to the fact that some physicians are critical of the AMA, Dr. Hall emphasized that "the goal of the AMA and the goal of these colleagues is the same: to provide the best possible health care for each and every American, at reasonable cost.

"I urge all physicians—those in practice, those in government, those in research and teaching, those in public health, those in administrative positions, those in all facets of medical activity—to come under the AMA's umbrella, to bring to us their hopes, their beliefs, their ideas and their vigor."

In closing his inaugural address, President Hall said, "The basic needs of man are food, clothing, shelter, education and health. Certainly physicians have some expertise in each of these areas. We know the requisites of good nutrition; we are able to give advice concerning the health aspects of clothing and shelter; we can contribute to education; we care for the sick, and we attempt to keep the healthy in that enviable condition."

(The Board of Trustees brought before the House the question of a constitutional convention, as suggested by Dr. Hall. Delegates voted to defer action until the 1971 Clinical Convention, meanwhile requesting informational "white papers" on the subject from the Council on Constitution and Bylaws and the Council on Long Range Planning and Development.)

Changes in the Organization

The Guam Medical Society of Agana, Guam, was accepted as a constitutent association of the AMA, bringing to 55 the number of state, commonwealth and territorial associations.

The scientific Section on Psychiatry and Neurology was separated to form two sections—the Section on Psychiatry and the Section on Neurology.

The Bylaws of the Association were amended to create a new membership classification. Under "Active Members," there now are two classifications: Regular Members and Direct Members. There is no change in the definition of Regular Members. Direct Members include service members, physicians employed by federal agencies, and interns and residents.

Right of Access to Medical Care

The House elaborated its existing policy regarding the right of access to medical care by adopting this statement: "It is the right of every citizen to have access to adequate medical care, but it is the responsibility of the citizen or of society to seek it. The American Medical Association will use all means at its disposal in an endeavor to make adequate medical care available to meet the needs of each person.

"In the spirit of inheritance of the Oath of Hippocrates, the AMA reaffirms its obligation to humanity. In this effort, the AMA cannot assume the responsibilities of government or the individual citizen. The AMA also recognizes the right of the physician to choose whom he will serve and the conditions under which he will render this service. These are integral essentials in the delivery of quality medical care."

Drugs and Drug Abuse

In addition to the action taken in direct response to President Nixon's speech to the House, delegates also took several other actions on the subject of drugs and drug abuse.

A report of the Council on Mental Health and its Committee on Alcoholism and Drug Dependence was filed for the information of the Association. It contains these recommendations for the medical profession:

1. Increased attention to alcoholism and drug abuse in the curriculum of medical schools.
2. Medical students, interns and residents should be encouraged to associate themselves with "street clinics" to establish links between the profession and young drug abusers.
3. Continued development and dissemination of reliable information to physicians and other health professionals.
4. Laws and regulations should be modified to recognize alcoholism and drug dependence as illnesses.
5. Closer liaison between medical societies and law enforcement and licensure bodies to deal jointly with the problem of physicians suspected of professionally misusing or personally abusing drugs.
6. Continually up-dated factual material for public consumption.
7. Increased emphasis on the responsible use of drugs for therapeutic purposes, both by the public and by physicians.

The House resolved to follow "studies being conducted to ascertain the relationship between proprietary drug advertising in the mass media and excessive use of self-prescribed drugs and drug dependence problems" and to "cooperate in every way possible in the studies being conducted by the FTC to assure the enactment of proprietary drug advertising regulations in the interests of protecting consumers."

Delegates also resolved to "urge all

physicians to limit their use of amphetamines and other stimulant drugs to specific, well-recognized medical indications."

In addition, the House resolved to go on record "favoring the implementation of stern measures for narcotic traffic control in Vietnam, as well as measures for the identification, prevention, diagnosis, and adequate treatment of addicts within the armed forces, with adequate provision for the availability of proper follow-up and aftercare."

Terminology and Definitions

Concerned with the growing use of the term "physician's associate" as opposed to the term "physician's assistant" to describe new health occupations, the Board and its Council on Health Manpower recommended (and the House agreed) that the term "physician's associate" be used only to denote another physician.

The House resolved that future editions of the publication AMA Drug Evaluations "avoid the use of the word 'irrational.'"

Delegates adopted three definitions in the area of peer review:

"Peer Review: Evaluation by practicing physicians of the quality and efficiency of services ordered or performed by other practicing physicians. Peer review is the all-inclusive term for medical review efforts. Medical practice analysis, inpatient hospital and extended care facility utilization review, medical audit, ambulatory care review, and claims review are all aspects of peer review.

"Medical Practice Analysis: A function of the medical society, or other organization authorized by the medical society, designed to coordinate all peer review efforts of a community. Medical practice analysis focuses on the development and application of criteria for optimal medical care, and evaluates the individual and collective quality, volume, and cost of medical care, wherever provided.

"Claims Review: Peer evaluation and adjudication of claims questions referred for peer review by any party with a valid interest in the case."

Definitions of other elements named in the "Peer Review" definition itself were referred back to the Council on Medical Service for further refinement.

Peer Review

Further in connection with peer review, the House resolved:

"That the American Medical Association and its constituent state associations reaffirm their support of voluntary mechanisms of review and education by physicians such as grievance committees, insurance review committees, and the numerous hospital review mechanisms, many of long standing;

"That the AMA and its constituent state associations continue to stress that peer review shall be considered a professional function and, as such, shall be carried out by physicians or under the sponsorship of the county and state medical societies;

"That this House of Delegates call on all state and county medical societies and the AMA to take an active responsible role in peer review and to document for the information of the public current functioning procedures and programs which are serving in the interests of delivering good medical care."

Better Health and Better Patient Care

With respect to teenage pregnancy, the House adopted the statements that "The teenage girl whose sexual behavior exposes her to possible conception have access to medical consultation and the most effective contraceptive advice and methods consistent with her physical and emotional needs" and "The physician so consulted should be free to prescribe or withhold contraceptive advice in accordance with his best medical judgment in the best interests of his patient." Earlier in that report, the House inserted the statement that "definite effort should be made to obtain consent from the minor's parents or legal guardian whenever possible."

Regarding maternal and infant care, the House adopted a report pointing out that "Application of recent advances in scientific knowledge and skills in the intensive care management of high-risk pregnant women and high-risk newborn infants will result in reduction of present maternal and infant mortality. A major contribution to such a program is the development of a centralized community (or regional) hospital-based newborn intensive care unit. Concentration of high-risk infant care programs in hospitals specially staffed and equipped to provide optimal care is a proven life-saving mechanism for infants at risk."

Concerned with the spread of venereal disease, the House resolved:

That medical societies be urged "to support education of patients and the public through more extensive and more imaginative use of all available media and through school curricula;" that the AMA "reiterates its support and cooperation with the National Commission on Venereal Disease in order to hasten the control of these diseases;" and that the AMA "strengthen in every way possible research efforts toward the development of vaccines for the active immunization of our population against venereal disease."

On health education in schools, the House resolved to encourage state and local medical societies "to establish active liaison with their school systems in order to provide lectures and appropriate educational support regarding: personal hygiene, the effects of tobacco and drugs, the problem of medical quackery and the role of physicians in maintaining good health."

To increase patient safety in hospitals, the House resolved that "medical staffs be urged to form a staff committee to cooperate with administration and lend guidance in developing safety programs that will include the concepts of prevention, detection, and correction, and which will fully utilize the expertise of physicians and other members of the health care team."

Considering the use of assistants in medical practice, delegates resolved that "the physician may properly delegate technical procedures to an allied health worker" but affirmed the principle "that whatever privileges may at any time be granted either to allied health workers or to independent limited practitioners, by law or otherwise, such grant in no way circumscribes the physician's authority in that field and in no way restricts the practice of medicine by the physician."

House Officers and Medical Students

The House commended "those county medical societies which have opened participation opportunities to House Officers" and recommended to county medical societies "that reduced membership dues be provided for House Staff members."

Delegates also resolved:

To request the Board of Directors of AMA-ERF "to investigate the feasibility of providing financial aid for the continuation and coordination of the SAMA-MECO Project." (Medical Education and Community Orientation.)

To "urge that the Congress support increased Federal aid to medical students."

"That residency training in community hospitals is worthy of strong and continued support."

To encourage "individual state societies to promote community programs in their states to provide facilities or loan programs for students for which the student agrees to return to the community after training."

That individual members of the AMA "assume sustaining membership in the Student American Medical Association."

And that the AMA "offer active support and counsel to the Student American Medical Association for their community health projects."

Additional Actions and Events

Delegates adopted a 39-page report on Physician Manpower and Medical Educa-

tion, prepared jointly by the Council on Medical Education and the Council on Health Manpower, with help from the Council on Medical Service.

They approved a progress report of the Board Committee on Professional Liability and filed for information an 89-page summary of Computer Systems in Medicine.

They adopted a Judicial Council report reaffirming the position "that the basic principles of a fair and objective hearing should always be accorded to the physician whose professional conduct is being reviewed. These basic guarantees are: a specific charge, adequate notice of hearing, the opportunity to be present and to hear the evidence, and to present a defense. These principles apply when the hearing body is a medical society tribunal or a hospital committee."

They adopted the report of the Council on Long Range Planning and Development which included these objectives for the AMA:

1. To maintain an active, viable organization representing the majority of physicians of the United States.
2. To serve as the central coordinating organization of medicine.
3. To serve as the representative of the medical profession in its relations with other health professions, industry, government, labor, consumers and other non-medical organizations.
4. To develop, stimulate and present scientific and professional programs and advances to the profession and public.
5. To continue its historic interest in all levels of medical education.
6. To assimilate recent medical graduates into the medical professional organizations.
7. To promote high standards of quality medical care.

Report of Board of Medical Registration and Examination of Indiana (July 1, 1970, to June 30, 1971)

HOUSE ACTION: Ordered filed.

Applications received for December 1970, June 1971 State Board Examinations (Med.) 560
Ineligible to take State Board Examination for various reasons .. 46
Approved for December 1970, June 1971 State Board Examinations ...514
Failed to appear for State Board Examinations 80
Applicants taking State Board Examinations 434
Candidates failed the State Board Examinations 150
Candidates from Indiana University Medical School taking State Board Examinations 216
Candidates from Indiana University Medical School taking State Board and failed. 1
Candidates taking Doctor of Osteopathy Examination 0
Candidates taking Doctor of Osteopathy Examination, failed ... 0
Candidates from foreign medical and other schools taking State Board Examinations 218
Candidates from foreign medical and other schools, failed 149
Over-all failure rate 34.5
I.U.M.S. Graduate, failure rate .... .04
Foreign medical school graduate, failure rate 68%
Candidates taking Chiropractic State Board Examination 0
Candidates taking Physical Therapy Examinations 41
Candidates taking Physical Therapy Examinations, failed 1
Candidates taking Podiatry State Board Examination 0
Candidates taking Podiatry National Board Examination, licensed 2
Candidates, Podiatry, failed 0

TOTALS, LICENSED BY EXAMINATION

	1968-1969	1969-1970	1970-1971
Medicine	257	355	284
Physical Therapy	31	23	41
Podiatry	4	11	2
Osteopathy	0	1	0
Chiropractic	0	0	0

Maternal Mortality Study Committee

HOUSE ACTION: Adopted.

Reports of Standing Committees and Commissions

Executive Committee

HOUSE ACTION: Ordered filed.

The Executive Committee, as usual, has met throughout the year to handle the housekeeping matters of the association and in many instances has referred matters that have come to their attention over to the Board of Trustees for their decision.

The minutes of the Executive Committee are published regularly in *The Journal* and copies of the minutes are available to the Reference Committee for their review. Therefore, this report will not be in detail as this information in detail is readily available.

The committee met following the close of the 1970 annual meeting, at which time Dr. Donald Kerr was elected chairman of the committee. New members coming on the committee were: Dr. Joseph Dukes, by virtue of being chairman of the Board, and Dr. Wilbert McIntosh, a member of the Board of Trustees.

Among some of the important activities of the committee was to request a meeting of the Executive Committee of the Indiana Regional Medical Plan to be held on December 16 for a discussion of the relationship between organized medicine and this group.

The committee also referred to the Board of Trustees and to the Commission on Legislation the action of the 1970 House of Delegates approving the creation of a Medical Disciplinary Board.

The committee also noted the forthcoming meeting in November of 1971 of a White House Conference on Aging and submitted the names of Dr. Malcolm O. Scamahorn, President, and Dr. Peter R. Petrich, President-elect, to the Governor for his consideration in appointing them as delegates to this meeting.

The Executive Committee forwarded a request to the AMA Judicial Council for a ruling concerning the physician's participation in profit-oriented HMOs.

The committee was busy during the first quarter of the year going over matters which were before the General Assembly.

The committee noted that the State of Indiana ranked eleventh in AMA membership.

The committee held a meeting with the officers of the Indiana Osteopathic Association and arranged for a meeting between this group and the Board of Trustees as a means of discussing the opening of better communications between the two organizations.

The committee accepted and referred to the Board of Trustees the return of a $5,000 gift to Medi-Tech, which sum has been returned and deposited in the Indiana Medical Foundation.

The committee, after a discussion with the Indianapolis Power and Light Company, entered into a new type of contract for the furnishing of electrical power which is anticipated will save money on the operation during the coming year.

Inasmuch as the association has been in its present home since 1962 without any redecoration, the committee did authorize

the repainting and the cleaning of the interior walls of the building.

Your committee also became a party to establishing an Indiana Perinatal Care Project, which is financed by a grant from the Board of Health.

The committee referred to the Board of Trustees many recommendations for appointment of members of the association to vacancies on AMA Councils and Committees.

The committee was conversant throughout the year with the proposal to make Marion County a testing center of an OEO and HUD program for delivery of medical care similar to an HMO program. This has been primarily a Marion County Medical Society matter but the Executive Committee has been kept informed as to developments.

This abbreviated rundown in no way attempts to cover the many matters which regularly come before your Executive Committee, but we sincerely hope that the membership has followed the actions of this committee as they have been reported in *The Journal* and we point out again that copies of all the minutes are in the hands of the Reference Committee.

In addition, there are reports on Medical Defense activities, *The Journal* and the Membership Report, as follows:

Medical Defense Activities

1. *Malpractice Cases.* A year ago, at the time of this report, August 1, 1970, the following three cases were pending before the committee:

Case 307—Suit filed March 22, 1962. Pending. (Expense to date, $1,042.73)

Case 309—Suit filed December 10, 1964. Closed February 1971. (Expense to date $450.00)

Case 313—Suit filed September 5, 1967. Pending.

Since August 1, 1970, and up to August 1, 1971, one new case has been filed.

2. *Medical Defense Fund Statement from August 1, 1970, to August 1, 1971:*

Bank Balance, August 1, 1970	$5,640.42
Receipts	3,433.75
Total Cash and Receipts August 1, 1971	$9,074.17
Disbursements:	898.82
Balance on hand August 1, 1971	$8,175.35

The Journal

A comparative report of *The Journal* operations over the past several years and the first six months of 1971 follows.

The first table shows the number of journal pages for the past six years (includes inserts).

This is a comparative report for the first six months of each year indicated.

Year	Reading	% Reading	Adv. Pages	% Adv. Pages	Total Pages	Av. No. Pages per Issue
1965	998	68	464	32	1462	122
1966	789	50	781	50	1570	131
1967	1041	58	751	42	1792	149
1968	1068	61	696	39	1764	147
1969	1041	67	509	33	1550	129
1970	1131	74	403	26	1534	128

The table below shows the total printing costs of *The Journal:*

Year	Printing Costs Total Printing Cost	No. of Pages (Inserts Excluded)
1966	41,795.32	1410
1967	49,958.15	1450
1968	50,709.62	1463
1969	42,916.62	1312
1970	44,520.84	1346
1971 (6 months)	21,189.18	600

A comparison of advertising revenues for the first six months of the last four years, with a like figure for 1971, is as follows:

State	1967	1968	
Medical Journal Adv.	23,468.96 3.056.68	24,153.24 7,200.10	
Bureau	26,525.64	31,353.34	
	1969	1970	1971
Sold direct by Journal	17,086.59 2,557.80	15,791.12 2,268.80	13,138.30 1,821.89
Totals	19,644.39	18,059.92	14,960.19

MEMBERSHIP REPORT

Total Members	December, 1969	December, 1970	
ISMA	4,482	4,505	
AMA	4,330	4,337	
	July 31, 1970	July 31, 1971	
ISMA	4,456	4,489	+33
AMA	4,291	4,236	—55

DISTRICT REPORT AS OF JULY 31, 1971

\+ GAIN
— LOSS

DISTRICT	ISMA	AMA
1	+10	+ 5
2	+ 6	— 3
3	+ 3	— 3
4	+ 5	— 1
5	— 1	— 2
6	— 5	—10
7	+ 9	+ 4
8	— 7	—17
9	+ 4	— 1
10	+ 6	+ 1
11	+ 9	+ 2
12	—14	—29
13	+ 8	— 1
	+33	—55

TOTAL NEW MEMBERS

DISTRICT	AS OF JULY 31, 1971
1	9
2	7
3	7
4	8
5	4
6	4
7	24
8	3
9	11
11	11
12	6
13	20
	130

DEATHS

DECEMBER 1970	AS OF JULY 31, 1971
59	37

MEMBERSHIP REPORT

	Dec. 31, 1970 ISMA	July 31, 1970 ISMA	AMA July 31, 1971 ISMA	July 31, 1971
1st District				
Gibson	12	12	11	11
Perry	8	8	7	7
Pike	3	3	2	2
Posey	7	7	6	6
Spencer	3	3	5	5
Vanderburgh	244	239	251	244
Warrick	7	7	7	7
TOTAL	284	279	289	282
2nd District				
Daviess-Martin	19	19	17	11
Greene	14	14	16	11
Knox	37	37	39	38
Owen-Monroe	83	83	88	78
Sullivan	13	13	12	11
TOTAL	166	166	172	149
3rd District				
Clark	47	47	47	41
Dubois	25	25	27	25
Floyd	44	44	45	42
Harrison-Crawford	9	9	9	9
Lawrence	27	27	28	24
Orange	8	8	7	7
Scott	6	6	5	5
Washington	7	7	8	8
TOTAL	173	173	176	161
4th District				
Bartholomew-Brown	55	55	56	48
Dearborn-Ohio	15	15	16	16
Decatur	11	11	13	11
Jackson-Jennings	23	23	21	21
Jefferson-Switzerland	30	28	29	26
Ripley	8	8	10	10
TOTAL	142	140	145	132
5th District				
Clay	13	13	13	13
Parke-Vermillion	17	17	17	17
Putnam	19	19	19	19
Vigo	119	119	118	116
TOTAL	168	168	167	165
6th District				
Fayette-Franklin	16	16	15	15
Hancock	26	26	27	27
Henry	39	39	38	35
Rush	12	12	13	13
Shelby	20	20	20	16
Wayne-Union	74	74	69	65
TOTAL	187	187	182	171
7th District				
Hendricks	22	20	23	19
Johnson	32	33	36	36
Marion	1072	1056	1057	1053
Morgan	19	19	21	19
TOTAL	1145	1128	1137	1127
8th District				
Delaware-Blackford	125	121	119	106
Jay	16	16	16	12
Madison	107	106	101	69
Randolph	17	17	17	14
TOTAL	265	260	253	201

9th District				
Benton	9	9	9	8
Boone	20	19	17	17
Clinton	14	14	14	14
Fountain-Warren	11	11	11	10
Hamilton	16	16	16	13
Montgomery	22	22	21	21
Newton	5	5	5	5
Tippecanoe	142	141	148	139
Tipton	11	11	11	11
White	7	7	7	6
TOTAL	257	255	259	244
10th District				
Jasper	8	7	8	8
Lake	464	453	447	413
Porter	51	51	62	60
TOTAL	523	511	517	481
11th District				
Carroll	7	7	8	8
Cass	36	36	38	33
Grant	72	71	76	75
Howard	65	65	70	70
Huntington	19	19	19	19
Miami	15	15	13	12
Wabash	33	33	31	24
TOTAL	247	246	255	241
12th District				
Adams	13	13	13	13
Allen	316	314	310	287
DeKalb	23	23	20	18
LaGrange	10	10	11	9
Noble	12	12	12	10
Steuben	11	11	10	10
Wells	46	46	39	39
Whitley	16	15	15	15
TOTAL	447	444	430	401
13th District				
Elkhart	114	114	111	102
Fulton	9	9	6	6
Kosciusko	13	13	14	14
LaPorte	96	94	97	86
Marshall	25	25	25	25
Pulaski	5	5	4	1
St. Joseph	232	232	242	240
Starke	7	7	8	7
TOTAL	501	499	507	481
SUMMARY				
1st District	284	279	289	282
2nd District	166	166	172	149
3rd District	173	173	176	161
4th District	142	140	145	132
5th District	168	168	167	165
6th District	187	187	182	171
7th District	1145	1128	1137	1127
8th District	265	260	253	201
9th District	257	255	259	244
10th District	523	511	517	481
11th District	247	246	255	241
12th District	447	444	430	401
13th District	501	499	507	481
TOTAL	4,505	4,456	4,489	4,236

DONALD M. KERR, M.D.
Chairman
WILBERT McINTOSH, M.D.
MALCOLM O. SCAMAHORN, M.D.
PETER R. PETRICH, M.D.
JOSEPH DUKES, M.D.
LESTER H. HOYT, M.D.
HUGH K. THATCHER, JR., M.D.

Medical-Legal Review Committee

HOUSE ACTION: Adopted.

The Medical-Legal Review Committee met on May 12, 1971, and made recommendations for revision of the Medical-Legal Professional Code. Another meeting is set for September 8; after that meeting a report will be submitted to the House of Delegates.

JOSEPH G. S. WEBER, M.D., *Chairman*
WALTER ABLE, M.D.
RAYMOND L. NEWNUM, M.D.

Grievance Committee

HOUSE ACTION: Adopted.

According to the Purposes, Rules and Procedure of the Grievance Committee, the committee has met in 1971 on January 31, March 14, May 16 and July 11. Another meeting is scheduled for September 12.

As of August 1, 1971, 23 cases were considered during the year. Nineteen new cases were filed. All cases except eight have been closed.

The ISMA Grievance Committee continued to follow the procedure of past years. (1) Receipt of complaint is acknowledged by a letter which states that action can proceed only after receiving the complainant's permission to forward a full copy of the complaint to the physician or physicians named therein along with identification of those filing the complaint. (2) Should the requested permission be given, the physician named is asked to attempt a personal settlement of the complaint. (3) Should the physician be unsuccessful or should he request that his county medical society attempt settlement, the matter is so referred with the ISMA Grievance Committee retaining the responsibility as the rules governing it require. A greater attempt is being made at the local level to settle differences before the state committee is involved.

The members of the Grievance Committee have spent a great deal of time in revising the Purposes, Rules and Procedure of the Grievance Committee as mandated by the 1967 House of Delegates. The revision of the rules has been given to the board of trustees for their study and action.

The Grievance Committee wishes to thank the members of ISMA who have been called upon to assist in discharging its responsibility. We have received excellent help.

WALLACE R. VANDENBOSCH, M.D., *Chairman*
JOHN M. PARIS, M.D., *Vice Chairman*
EUGENE S. RIFNER, M.D., *Secretary*
KENNETH L. OLSON, M.D.
WILLIAM D. PROVINCE, M.D.
RICHARD S. BLOOMER, M.D.
ROBERT G. YOUNG, M.D.
WILSON L. DALTON, M.D.
HUGH K. THATCHER, JR., M.D.
WILLIAM R. NOE, M.D.

Student Loan Committee

HOUSE ACTION: Adopted.

The Student Loan Committee has had one meeting during the past year, at which time a loan of $1,000 was granted. Two loans of $1,000 each were granted to two students who already have loans of $1,000 each. Only one new application was received.

Under the Guaranteed Loan Plan with the Indiana National Bank, which was instituted December 1, 1963, the Association has on deposit with the bank $20,810 to guarantee loans totaling $260,000. As of July 31, 1971, 108 loans, totaling $95,500 have been granted under this plan. Forty-one loans have been converted to installment loans in the amount of $42,965.29; eight loans totaling $7,700 have not been converted to installment loans; two loans of $1,000 each have been repaid in full.

A report on the Loan Fund which was under the Association management from October 1955, to December 31, 1963, follows:

Total loaned to 117 students	$58,458.36
Total repaid as of July 31, 1971	$58,356.60
Total amount outstanding, July 31, 1971	$ 101.76

Of the 117 who received loans,

116 have repaid in full
1 is making payments

Total due on above loan still outstanding	$ 101.76

The 1970 House of Delegates approved the report of the Reference Committee which asked the Board of Trustees to revaluate the Student Loan Program as the Reference Committee did not believe the loan fund was serving the purpose which the House of Delegates originally intended.

The Student Loan Fund does provide an essential service to students in need of financial help and it is the recommendation of the Student Loan Committee that this type of loan procedure should be continued.

HUGH K. THATCHER, JR., M.D., *Chairman*
JAMES O. RITCHEY, M.D., *Vice Chairman*
JOE DUKES, M.D., *Secretary*
MALCOLM O. SCAMAHORN, M.D.
LESTER H. HOYT, M.D.
GLENN W. IRWIN, M.D.
WILLIAM G. BANNON, M.D.

Sports and Medicine

HOUSE ACTION: Adopted.

The Committee on Sports and Medicine of the Indiana State Medical Association was expanded in 1970-71 to a total of 12 physicians interested and oriented to athletic medicine. The physicians were chosen to represent different regions of the state. Liaison was also established with the newly formed Football Coaches As-

sociation and the commissioner's office of the IHSAA, who would have ex-officio members on the committee.

The Committee on Sports and Medicine sponsored a Conference on Athletics and Medicine on November 12, 1970, at the Methodist Hospital in Indianapolis. Twenty-seven physicians in addition to sixty-six coaches, trainers and athletic directors attended the all-day program. This meeting was well received and will, hopefully, be continued yearly. The summary of the conference has already been forwarded to the ISMA office.

In the area of public and professional information, the committee sponsored a booth on athletic medicine at the ISMA state meeting in October 1970. The committee again will sponsor a booth and endeavor to improve on both the facilities and information to be provided in 1971.

Also, as a matter of public information, the committee made known through the news media the dangers of the heat intolerance in early football drills and outlined certain measures to prevent heat stroke. A warning of the dangers of rapid and excessive weight loss in wrestling was also made by the committee. These recommendations were published in newspapers throughout the state and received radio and TV coverage.

The committee also made a recommendation to the IHSAA of a rules change in football which would prohibit the "crackback" block below the level of the hip by flankers or wide receivers. A questionnaire was sent to all coaches in the state regarding the suggestion and 80 percent of the coaches responding concurred with the committee's feelings.

The committee will continue to function to promote education in athletic medicine in both the professional and lay community. The committee will also serve to recommend any new medical safeguards in the field of athletics that it might deem necessary and serve as liaison to physicians, coaches, trainers, and all others interested in sports medicine throughout the state of Indiana.

BRAD BOMBA, M.D., *Chairman*
THOMAS A. BRADY, M.D.
JAMES H. BELT, M.D.
JAMES B. WRAY, M.D.
GILBERT M. WILHELMUS, M.D.
ARTHUR L. MOSER, M.D.
GARLAND D. ANDERSON, M.D.
THOMAS D. FOY, M.D.
LESLIE M. BODNER, M.D.
PAUL A. MACRI, M.D.

Medicine and Religion

HOUSE ACTION: Adopted.

No one likes to pass up a good thing if he knows about it. The good thing in this case is the help a patient can get by his doctor and his minister working together to aid him in his individual problems.

The Committee felt that while ministers and doctors do work together for the good of patients, many opportunities for such working together are overlooked. The reasons are many. Most doctors will concede that there is a need for doctors and ministers to work together for the good of the patient, but demands in other areas seem to crowd out the best intentions.

It was the opinion of the Committee that not only would the patient be benefited by the closer cooperation between minister and doctor in the care of these patients, but the doctor could obtain considerable help in solving a certain problem of a patient if the minister were to share part of the load. It is not uncommon for a doctor to struggle along with a difficult case when it is quite apparent that, in addition to the medical aspects of the case, there are overtones that would be best solved by skills that a minister has. In short, the complete treatment of such a patient is not a pill, but a program and a program involving the minister. This concept has not been readily "bought" by the medical profession.

The problem this Committee sought to solve was: "We have a good product (cooperative help), how do we sell it?" Taking a cue from the Cancer Society in their promotion of cervical cancer detection by the use of the "pap" smear, the patient first was sold on the necessity of having this "pap" smear. Then she went to the doctor and requested the "pap" smear whereupon the doctor provided the service. Using this same approach, we felt it would be possible to develop appropriate public service announcements and other forms of publicity bringing out the advantage to the public of the team approach between minister and physician. Such announcements would have to be appropriate and in good taste. The Committee requests the board of trustees to consider this proposal and give approval or disapproval of this concept. Then details be worked out and submitted to the Board of Trustees for approval before any actual approach promotion is made.

We need to gather facts in two areas: (1) doctors who are interested in the field of Medicine and Religion in their communities, and (2) activities which are being carried out now which are in the field of Medicine and Religion.

The editor of the ISMA *Journal* has agreed to accept for publication an article publicizing the program in the field of Medicine and Religion. The committee will search for an author who can best write such an article. In addition, doctors in the state who are known to be interested in the field of Medicine and Religion will be contacted and requested to seek out others that they are aware of, who are interested in Medicine and Religion. Through this doctor-to-doctor contact, an ever-enlarging list of doctors over the state can be interested. It has been the experience over the country, as reported in national Medicine and Religion meetings, that the programs move only because individual doctors are interested in making the program move, and it is important to identify these individuals.

The problem of establishing hospital chaplaincies part-time, full-time, or on a trial basis was considered and it was felt the best approach would be to develop a letter to be sent to boards of trustees of the hospitals of the state, explaining chaplain service. Dr. Soper will author a letter for this purpose.

A third effort will be directed toward engaging seminary students to be more exposed to problems of the parishioner who is ill, so that the seminary student by the time he has graduated, will be more sophisticated in medical matters. In addition, it was felt that the medical student needs similar sophistication in matters of religion. It is felt that a great deal could be done to the good of the patients. Introducing more material into the curriculum, now crowded to the hilt, might be difficult but still possible.

George Washington University has a successful program in which seminary students and medical students meet at regular intervals in the evenings to discuss mutual problems. Several Indiana University Medical School students have been approached, and have indicated that this might be possible at Indiana University Medical School.

The last item considered was the provision of a Medicine and Religion booth at the Indiana State Medical Association meeting in October. The Committee requests of the Program Committee that space be allowed for such a booth. An effort will be made to have the booth manned by a doctor and a minister, as has been done in other state meetings.

BURTON E. KINTNER, M.D., *Chairman*
HUNTER SOPER, M.D.
EDWIN B. BAILEY, M.D.
JOHN C. SLAUGHTER, JR., M.D.

Supplemental Report of Medical-Legal Review Committee

HOUSE ACTION: Adopted.

Your Medical-Legal Review Committee recommends the adoption of a change in the existing Medical-Legal Professional Code by deletion of the phrase "entire testimony," appearing in Article III, Sec. 3, paragraph 3, and replacing it with the phrase "that portion of a transcript which fairly and accurately presents the issues in dispute."

We further recommend that the revised code be published in *The Journal* of the Indiana State Medical Association.

Convention Arrangements

HOUSE ACTION: The scientific program and exhibits constitute the report of this commission. Efforts of committee are commended. Motion tabled to start final meeting of House of Delegates at 9 a.m.

Future Planning Committee

No report.

Reports of Commissions

Constitution and Bylaws

The Commission on Constitution and Bylaws had several matters referred to it by the Board of Trustees and previous actions of the House of Delegates and we make the following recommendations for changes in the Constitution and Bylaws.

HOUSE ACTION: The following amendments to the Constitution were introduced and approved but will lay over until the 1972 meeting before final action is taken.

Constitution

Constitutional change: This is being presented at this meeting for the first time and, as required in the Constitution and Bylaws, the proposed amendment shall lay over for one year for final action to be taken in the annual meeting in 1972.

Article V—In accordance with the recommendation of Past President Steen in his speech before the 1970 meeting of the House of Delegates, which the House approved and referred to us for proper language, we have prepared the following: Therefore, Be It Resolved, to amend Article V of the Constitution by adding an additional paragraph after the first paragraph to read as follows: "All sessions of the House of Delegates shall be open to all members in good standing of this Association for observation."

The Commission also had referred to it from President Steen's remarks the suggestion that the words "temporary absence" should be inserted in Section 7, Article IX of the Constitution. Your Commission feels that this is unnecessary as the provisions of this Article clearly set forth who shall serve in the absence of the president and believes the words "temporary absence" would be difficult to define and would serve no true function. Therefore, we recommend that no changes be made in Section 7, Article IX of the Constitution.

Bylaws

HOUSE ACTION: The following amendment to the Bylaws were adopted.

The following are recommendations for changes in the Bylaws and, if approved in this session, will become effective with the final vote on these recommendations.

Your Commission has received testimony with respect to the handicap placed upon Blue Shield by limiting the terms for elected M.D. members to their Board. It is the opinion of this Commission that the term of office of elected doctors to their Board of Directors is only a part of their problem. We are sympathetic to the request for unlimited terms of office. We are also convinced that this will not solve the problem or satisfy the individual members of the Indiana State Medical Association unless other recommendations are honored and implemented to assure the delegates that elected Board members are representing the membership of the ISMA.

We further recommend that the Indiana State Medical Association conduct seminars to prepare these elective or nominated members for their duties and that the trustees should make an annual report back to the constituent county medical societies of the record of their delegates.

We therefore make the following recommendation: "Therefore Be It Resolved that Chapter XXXII, Section 10 of the Bylaws shall be revised by deleting the last paragraph starting with the word "however" and, in lieu of the current last paragraph, a new paragraph to be numbered "b" be inserted to read as follows: "Any member selected or nominated to serve on the Board of Directors of Mutual Medical Insurance, Inc., (Blue Shield) may serve an unlimited number of three year terms as approved by his constituent county medical societies. The Board of Directors of Mutual Medical Insurance, Inc., (Blue Shield) should prepare a list of needed qualifications for nomination to this office."

Your Commission also had referred to it by the Board of Trustees the question of creating an office of Speaker and Vice Speaker of the House of Delegates. It is the considered opinion of this Commission that the office of Speaker would require knowledgeable acquaintance and opportunity of study of our problems before he could be effective. There would be danger of creating an unwanted and conflicting source of power.

Therefore, this Commission believes that the president's load could be lightened by prescribing definite duties to the president-elect. We believe this apprenticeship would tend to improve the efforts of both offices and preserve leadership of the Association to the office of its president. We therefore recommend that the offices of Speaker and Vice-Speaker not be created.

GORDON S. FESSLER, M.D.,
Chairman
ELI GOODMAN, M.D.
PAUL B. ARBOGAST, M.D.
BERNARD B. ROSENBLATT, M.D.
DONALD B. GARVIN, M.D.
GLEN WARD LEE, M.D.
JOHN M. RECORDS, M.D.
WALLACE A. SCEA, M.D.
WILLIAM J. MILLER, M.D.
GEORGE YOUNG, M.D.
EVRETT SMITH, M.D.
WILLIAM B. HUGH, M.D.
CHARLES B. HUGHES, M.D.
CHARLES PLANK, M.D.

Aging

HOUSE ACTION: Ordered filed.

The Commission met on January 31, 1971, April 18, 1971 and July 11, 1971, and discussed the resolutions that were submitted to the 1970 House of Delegates. It was felt that the members of the Commission had adequately represented and supported these resolutions in the Reference Committee, but that the Reference Committee had closed minds with the viewpoint that this would open up administrative difficulty, in that partial disability would be difficult to administer. We do not feel that it is the province of the Indiana State Medical Association to judge whether the administrative problems are difficult, merely to judge the principle of partial disability, and allow the legislators to write appropriate administrative policies. It was our opinion that this had been handled quite well in the Social Security Department; but that the Veterans Administration had not handled partial disability well. There is, therefore, precedent for managing the partial disability through the Social Security.

It was moved that this resolution should be resubmitted. It had also been requested that we submit a report of the statement of policy, and a copy is attached.

The Commission, through its chairman, participated in meetings to work out policies to be submitted to the state meeting on aging in Bloomington, and to be further presented to the President's Commission on Aging in Washington, D.C. in the fall.

It was the Commission's general opinion that the Presidential Commissions are probably worthwhile, they do present opportunities to think through the various aspects of Aging; however, the major emphasis would come from Washington rather than from the grass roots.

W. R. VAN DEN BOSCH, M.D., *Chairman*
JOEL W. SALON, M.D.
RAYMOND DUNCAN, M.D.
A. W. CAVINS, M.D.
JAMES R. GUTHRIE, M.D.
JOHN O. BUTLER, M.D.
THEODORE R. HAYES, M.D.
DANIEL RAMKER, M.D.
THOMAS A. ELLIOTT, M.D.
DANIEL BERNOSKE, M.D.
HAROLD E. RENDEL, M.D.

Statement of Policy of the Indiana State Medical Association, as presented by the Chairman of Commission on Aging at the State Meeting for Aging in Bloomington, May 15, 1971.

It is the Policy of the Indiana State Medcial Association as a professional organization of medical doctors:

1. To deliver medical care to the aged. This would include, but is not limited to, early recognition of disease, treatment of disease and the application of preventive practices to preserve health.
2. To recommend, counsel and advise in the construction of facilities to expedite the efficient and economical delivery of the above health care.
3. To consult and advise on the education of the public regarding health care and delivery of health services so that the public is made aware of the importance of all of the current scientific knowledge that would be applicable to their personal and community health.
4. To make every possible effort to see that every citizen has health facilities available and, wherever possible, that the choice of physicians be entirely at the discretion of the patient, and that the physicians have a free choice of the method of treatment. That free choice of the facilities and none of the patients or physicians be denied the use of full range of medical treatment that is available.
5. That the physician's dedication to the preservation of life be to the preservation of the complete socio-psychological as well as physiological life.

Medical Economics and Insurance

HOUSE ACTION: Approved

The Commission on Medical Economics and Insurance has met five times during the past year. We submit the following report:

1. Insurance Programs
   A. *Indiana State Medical Association Disability Program.* This program has been a very stable program after five years of experience. There is now available a maximum benefit of $1,500 per month. Because of favorable underwriting experience, the benefits have been increased 10% for the current year. This increase is subject to a yearly review depending upon the underwriting experience. The renewals for this program are nearly 100%. A business overhead program is expected to be offered this fall. This will be tax-deductible, a 15 or 30-day waiting period, with death benefits payable to the estate of the insured.
   B. *Indiana State Medical Association Group Life Insurance.* This program has been accepted by a much larger number than was considered likely at the outset of the program. The Valley Forge Life Insurance Company has been very pleased with the response. Over $5,000,000 of insurance is now in force. As of this fall, the maximum amount of insurance available to Indiana State Medical Association members in this group program will be increased to $40,000 before the age of 60, and the conversion privilege is retained.
   C. *Indiana State Medical Association Group Automobile Insurance.* This type of insurance is currently being studied. The Commission has received approval from the Board of Trustees to proceed with a feasibility survey of the Indiana State Medical Association membership if an acceptable policy is received. It is anticipated that this survey may occur during the late months of 1971.
   D. *Medical Liability Coverage.* The Commission has been unable to obtain firm commitment from any insurer even though CNA is currently engaged in negotiation with the AMA regarding this matter. CNA was unwilling to participate with the Indiana State Medical Association in a program because of the lack of interest on the part of Indiana State Medical Association members when surveyed last year to participate in such a program. The Commission is monitoring this field closely and has met on two occasions with representatives of other insurance companies. Additional information is to be studied. A tentative proposal has recently been received from one major company and a second major company has expressed an interest in discussing coverage of Indiana State Medical Association members. If additional information or definite proposals are received, a supplementary report will be presented to the House of Delegates.

II. *Matters Referred to the Commission by the Board of Trustees and by the House of Delegates.*
   A. *Resolution 69-27.* A review of Blue Shield-Blue Cross benefits. The Commission held that it would be impossible to review each of the nearly 400 programs offered by Blue Cross-Blue Shield. The Commission would point out that most programs are negotiated between management and a union with dollar amounts stipulated and that the coverage is based on the available plans which, in turn, are based on the negotiated dollar amount. The Commission would make the following recommendations:
      1. Each health insurance company should provide each policyholder with a summary of benefits available under the policy in easily understood language.
      2. Encourage Blue Shield and Blue Cross to increase coverage whenever and wherever possible, particularly in the realm of outpatient and diagnostic coverage.
      3. Provide better communication with physicians and with policyholders regarding the policies that are held, in order that all will have a more realistic understanding of the health care financing mechanism and the limitations of many policies.
   B. *Resolution 70-3.* A study of the development of relative value

schedules indicates that they have become "a way of life" for many specialty groups and many county societies. The Commission recommends that the principle of relative value schedules be considered a matter of local option, by county medical societies or the Indiana State Medical Association. The Commission wishes to point out that relative value schedules, peer review, medical foundations, and HMOs cannot provide all the answers to health and to health care financing. There is a fear among the members of the Commission that these programs can lead to much misunderstanding. It is the intention of the Commission to follow closely the plans for HMOs in their relationships with insurers, particularly the Blue Cross and Blue Shield program.

C. *Resolution 70-4.* Fee-negotiating mechanisms. There appears to be little or no functional fee-negotiating mechanism existing at the present time, except perhaps the relative value schedules in association with the foundations or programs similar to Champus. No satisfactory method has been uncovered by the Commission regarding a satisfactory fee-negotiating mechanism. At the 1971 annual meeting of the AMA in Atlantic City, the House of Delegates adopted the following report of the AMA Board of Trustees: "It would be inappropriate at this time to seek such new mechanisms to provide for the negotiation for professional fees or to deal with the subject of how physicians render their services."

We might suggest that the only real fee-negotiating mechanism is a union or a guild.

D. *Medical Foundations.* Regarding medical foundations, the Commission believes that medical foundations include many facets:
1. Medical care; 2. Prepayment; 3. Peer review.

These are only a few of the factors relating to medical foundations. It is the belief of the Commission that, since peer review is a very important part of the foundation concept, basically a decision must be made by the Board of Trustees or by the House of Delegates on the applicability of county-wide or state-wide peer review in relationship to the county societies or Indiana State Medical Association. The society must consider whether an Indiana State Medical Association foundation would merely provide or perform claims review and utilization review, or whether it should merely participate in review, or participate in actual medical care procedures. It is the opinion of the commission that the latter concept would be impractical.

E. *Parameters, Medicaid and Medicare Services.* The commission approved the following statement to be sent to the Board of Trustees: "The commission has considered the parameters for Medicaid and Medicare services as presented to the Board of Trustees by Blue Shield." It found the parameters to be completely unacceptable. The Commission recommended to the Board of Trustees that they inform Blue Shield that these parameters are entirely unacceptable to the Indiana State Medical Association and to its members. If Blue Shield has evidence of irregular medical practice, it should present such information to the proper medical authorities and not presume there are irregular practices. Such parameters are restrictive rather than conducive to good medical care. It would appear now that dollars have become the primary consideration for the care of the Medicaid and Medicare recipients rather than the promised good medical care.

F. *Payment to assistant surgeons.* The Commission on Medical Economics and Insurance has considered the matter regarding payment to be made to assistant surgeons. The following is our recommendation:

> In accordance with previously established Indiana State Medical Association policies we believe the assistant surgeon, should be compensated for his service, regardless of whether an intern or resident might be available as an assistant. Payment should *not be* made to an intern or resident for providing assistance in surgery.

The Commission has recommended that a pamphlet entitled "Health Insurance—Which Plan for You?" published by the AMA is an excellent reference for those interested in the subject. The Commission has recommended that this brochure be made available to the members of the Association and to their patients. The Commission further recommends that all members carefully read the article on medical care foundations that appeared in the Indiana State Medical Association Journal in January 1971.

KENNETH O. NEUMANN, M.D.
Chairman
MORRIS E. THOMAS, M.D.
PAUL W. HOLTZMAN, M.D.
LEO R. NONTE, M.D.
HARRY J. STOLLER, M.D.
VINCENT J. SANTARE, M.D.
EDWARD J. PLOETNER, M.D.
JOHN L. FRAZIER, M.D.
JACK W. HANNAH, M.D.
THOMAS J. CONWAY, M.D.
R. JAMES BILLS, M.D.
WILLARD T. BARNHART, M.D.
LARRY G. COLE, M.D.
ROBERT C. STONE, M.D.
PAUL M. INLOW, M.D.

Medical Education and Licensure

HOUSE ACTION: Adopted.

The Commission met on January 31, 1971, April 18, 1971, June 6, 1971 and September 12, 1971. In addition to the regular Commission members in attendance, Dr. Steven Beering, Dr. Raymond Murray and Mr. Peter Foster (SAMA representative) attended as guests and consultants.

Materials, subjects for study and resolutions assigned to this Commission were: (1) Resolutions 70-20, 70-28, 70-32. (2) Ivy Tech matters. (3) SAMA MECO project.

Other subjects and problems considered by the Commission were: (1) Physicians' Assistants, (2) Continuing Medical Education, (3) Student-Faculty-ISMA Retreat, (4) Preceptor Program, (5) Proposed Medical Practice Act, (6) Indiana University School of Medicine, (7) Foreign Medical Graduates.

Action taken on materials, subjects and resolutions are as follows:

1. a) Resolution 70-20 was referred to the Ad Hoc Committee for Physicians' Assistants with a recommendation for registration rather than licensure for Physicians' Assistants.

   b) Resolution 70-28 was considered. A motion was made and passed that the Commission feels that it has adequate representation and adequate liaison with the Governor's Commission and the Indiana

University School of Medicine and would continue to keep the Board of Trustees informed. This resolution was endorsed by the Commission.

c) Resolution 70-32. The Commission felt that since the matter of Foreign Medical Graduates had been adequately discussed and acted upon by the Board of Trustees of the ISMA, no further action by this Commission was necessary.

2. Ivy Tech matters related to curriculum changes in the nurses training program—for example, the ORT program curriculum. It was felt that since this was an internal matter it would be a mistake for the Commission to take a stand. No action was recommended by the Commission.
3. The MECO project of SAMA.

The Commission had previously approved the principle of the MECO project.

A report by a SAMA representative was given and discussed by the Commission.

The action and recommendations on other subjects and problems considered by the Commission are as follows:

(1) Physicians' Assistants—At the January 31 meeting there was much discussion and study of the problem. The results of the survey of the specialty sections of ISMA made at the last annual meeting were circulated.

Since the ISMA Board of Trustees had formed an Ad Hoc Committee on Physicians' Assistants, no further action was taken and this Commission moved to refer all information and matters regarding Physicians' Assistants to the Ad Hoc Committee.

(2) Continuing Medical Education—A subcommittee of the Commission was formed to study and make recommendations to the Commission on continuing medical education as a requirement for ISMA membership. This subcommittee presented recommendations for adoption by the Commission. These recommendations were amended according to request by the Commission and are as follows:

1. That the Commission on Medical Education and Licensure establish a statewide mechanism for accrediting non-university programs following the guidelines of the physicians' recognition award.
2. That all such programs be annually re-evaluated and published for the information of the membership.
3. That the Indiana University School of Medicine be commended for the quality and quantity of programs offered and that the school be encouraged to continue its excellent cooperation and that it attempt to offer as many programs as possible outside the Indianapolis area.
4. That adjacent areas in establishing programs strive to coordinate their efforts to avoid reduplication.
5. That the Commission should continuously assure itself that the programs being offered are tailored to meet the needs of the physicians.
6. That when the above have been accomplished, the House of Delegates of the Indiana State Medical Association be requested to make mandatory participation in the continuing medical education program to fulfill the requirements of the physicians' recognition award.
7. That the accreditation program should be completed by January of 1972, allowing action by the House of Delegates in the fall of 1972.
8. That retention of membership in the Indiana State Medical Association will necessitate successful fulfillment of the 150 hours of continuing medical education, as outlined by the physicians' recognition award, or as may be modified by the House of Delegates of the Indiana State Medical Association.
9. That all of the above be implemented based on the conviction that a program of continuing medical education will result in improved quality of patient care.

The Commission accepted these recommendations with the request that the subcommittee prepare them in the form of a resolution to be presented at the annual meeting in October.

(3) Student-Faculty-ISMA Retreat—The report of last year's retreat was studied and recommendations for the next retreat were made. The Commission has offered its help in planning the next retreat.

(4) Preceptor Program—Closer liaison is being maintained between the Commission and the Indiana University School of Medicine with Dr. Egger of the Commission and Dr. Alan Fischer, chairman of the new program, Family Medicine, at Indiana University School of Medicine. Some recommendations have been made and are under consideration to strengthen the program and make it more relevant. A preceptor training seminar is being considered. This will be a joint effort by the ISMA Commission and the I.U. School of Medicine.

A certificate of recognition to be presented by the University to the Preceptors was presented to the Commission by Dr. Beering.

(5) Proposed Medical Practice Act—This was presented to the Commission by Dr. Merritt Alcorn, president of the State Board of Registration and Examination, and discussed. The Commission is studying this proposed Act which will be modified and presented to the legislature after careful preparation.

The Commission recommended it sponsor meetings over the state, probably in four areas, to inform the state physicians regarding the Act and ask their guidance in the final presentation.

(6) Legislation on Foreign Medical Graduates—House Bill 1260 was studied by the Commission. The interpretation of the State Board of Registration and Examination was presented by Dr. Alcorn. The Commission is concerned about the new law, particularly the two-year temporary licensure under a sponsor or preceptor.

(7) I.U. School of Medicine—Throughout the year, extremely close liaison has existed between the Commission and the I.U. School of Medicine. Always attending the meetings, either as a member or guest, were representatives from the Dean's office. They reported on the status of the school, the admissions and the admission procedures and the 7-Center plan. They have cooperated in every way with ISMA and contributed much to the work of the Commission.

The Commission wishes to thank the ISMA staff for its help in the work of the Commission. I wish to thank also each of the members of the Commission, as well as the guests who have attended to help in the business of the Commission.

FRANKLIN A. BRYAN, M.D.,
Chairman
GEORGE T. LUKEMEYER, M.D.
NORMAN J. WILSON, M.D.
DANIEL H. CANNON, M.D.
SHOKRI RADPOUR, M.D.
MERRITT O. ALCORN, M.D.
ROSS L. EGGER, M.D.
PETER J. PILECKI, M.D.
JENE R. BENNETT, M.D.
GLENN W. IRWIN, JR., M.D.
STEVEN C. BEERING, M.D.
HARRY GORDON, M.D.
WAYNE CROCKETT, M.D.
GEORGE G. MORRISON, JR., M.D.
GILBERT J. HIMEBAUGH, M.D.
PETER R. PETRICH, M.D.
BETTY DUKES, M.D.

Supplemental Report of the Commission on Medical Education and Licensure of ISMA

HOUSE ACTION: Adopted.

Additional business was accomplished at the last meeting of the Commission on September 12 which was not included in the published Annual Report. The following matters were acted upon and recommendations were made:

I. The Family Practice Preceptorship Program.
II. Continuing Medical Education.
III. Proposed Uniform Medical Practice Act.
IV. Physician-Faculty-Student Retreat.
V. Licensure of graduates of foreign medical schools.

I. PRECEPTOR PROGRAM

1) A proposed reorganization of the Family Practice Preceptorship Program was approved by the Commission. This would place the program under the administrative control of the Department of Family Practice of I.U. School of Medicine, with a policy-making committee composed of the following:
   a) A representative from the ISMA Medical Education and Licensure Commission, preferably the chairman of the Preceptorship Committee.
   b) An ISMA member-at-large
   c) A representative of the Indiana Academy of Family Physicians, preferably the chairman of the Education Committee.
   d) The director of the Family Practice Program at I.U. as chairman of this committee.
   e) A representative of the junior and senior medical classes, to be chosen by the GP Club annually.
2) A one-day training and indoctrination seminar for preceptors was approved and is scheduled for November 11.
3) A certificate of recognition to be presented to Family Practice Preceptors by the Indiana University School of Medicine was recommended by the Commission. This is in recognition of outstanding contributions to the educational program of the School of Medicine and ISMA.

II. CONTINUING MEDICAL EDUCATION

Two resolutions relating to Continuing Medical Education were prepared for presentation to the House of Delegates. We respectfully request your consideration and favorable action upon:

1) Resolution 71-14, Continuing Medical Education requirement for Indiana State Medical Association membership; and
2) Resolution 71-15, Statewide Continuing Medical Education Accreditation System.

III. PROPOSED UNIFORM MEDICAL PRACTICE ACT

The Commission recommended that it sponsor four regional meetings for the purpose of disseminating information to, and educating the membership of ISMA and receiving its recommendations for the preparation of a new Uniform Medical Practice Act. The sites suggested are Gary, Fort Wayne, Indianapolis and French Lick or Bloomington.

IV. PHYSICIAN-FACULTY-STUDENT RETREAT

The Commission recommended that the Indiana State Medical Association Board of Trustees approve and report to the House of Delegates the conclusions developed at the ISMA-Student-Faculty Retreat and refer them to the Commission on Medical Education and Licensure for discussion yearly. It was further recommended that the retreats be so structured in the future as to assure the development of conclusions.

V. LICENSURE OF GRADUATES OF FOREIGN MEDICAL SCHOOLS

The Commission was very concerned with recent efforts to pressure the Indiana Board of Registration and Examination into bending the new licensure law to permit easier entry of graduates of foreign medical schools. It felt that Mr. Willkie and Southern Indiana, Inc. were to be commended for their efforts in pointing out and publicizing the great need for more physicians in Indiana and attempting to assist in solving this problem. However, since the emphasis regarding this difficulty in entry to the health care system, due to our state licensure law, has been misplaced, the Commission felt that strong support by the ISMA for the Indiana Board of Registration and Examination in its interpretation of and compliance with the law is necessary. The commission therefore prepared a statement for the House of Delegates and respectfully requests that this body consider a similar positive statement in support of this Board.

"The Indiana Sate Medical Association compliments Southern Indiana, Inc. and Mr. Philip Willkie in their efforts to improve the shortage of physicians in Indiana. The ISMA wishes to point out that the licensure laws are for the purpose of assuring that only properly trained and qualified physicians are licensed, in order to assure high quality medical care for patients and to maintain the high standard of medicine that Indiana esjoys. We therefore urge the Indiana State Board of Medical Registration and Examination to comply with all provisions of that law, and express our continued strong support in this effort."

Public Health

HOUSE ACTION: Ordered filed.

The Indiana State Medical Association Commission on Public Health held four meetings this last year and acted on a large number of issues, as follows:

Resolution 70-15 *on physician exams for school employees*: It was decided that the intent of the law was tuberculosis control and not physical examinations, so the Commission recommended the same action as it took one year ago—namely, that the word "physical" be eliminated from line 10 of House Enrolled Act 1290, and the Board of Trustees was so notified.

House Bill 1176: This law provided for county council and commissioner control over salaries in the Department of Health. The Commission decided that this was an unwise provision and informed the Commission on Legislation of our strong disapproval. As passed later by the legislature, this gives the commissioners budgetary control over only non-medical personnel of the Health Department.

Resolution 70-27: To develop a program under the auspices of Indiana State Medical Association to obtain information and formulate recommendations on drugs and euphoriant agents for the guidance of our members and to transmit these results to the membership and provide the public with recommendations: The Commission felt that authoritative information was already available on this subject. It obtained a huge bibliography from the State Board of Health. A letter was composed to this effect and will appear along with all articles probably in the August *Journal* of the Indiana State Medical Association.

The above resolutions were the main ones referred to the Commission but many others were also handled. Subjects included glass storm doors, environmental control, public health departments, mobile

homes, immunization of school children, regulation of hearing-aid dealers.

Eagle Creek Watershed Feedlot: We wholeheartedly supported the position of the Indiana Academy of Pediatrics to the effect that animal feedlots should not be located in present or future watersheds of reservoirs for recreational or municipal water supply, and we recommended this to the Board of Trustees.

The Commission spent some time on *the subject of V.D.* We received a letter suggesting our Commission recommend semi-annual serological tests for syphilis on college students, or at least a pilot program doing this. We decided that V.D. was receiving adequate publicity and its recognition would best be continued by alerted doctors in general, especially college doctors. Another letter came to the Commission concerning V.D. from La-Porte County wanting help from Indiana State Medical Association in a school education program. The magnitude of this V.D. problem is such that the subject should be on the agenda of the Commission next year.

Program for the Indiana State Medical Association annual meeting: Continuing the effort of the Commission on Public Health of one year ago, discussion was held on having a program on pollution at the fall meeting. Phone calls were made to the program committee and a letter written suggesting resource persons for this subject.

Safety Glasses: The Commission recommended by a letter to the State Ophthalmological Society that legislation be introduced to the State Legislature to require safety glasses for all spectacles.

Full-time Health Departments: Feeling that many of the problems of public health would be better solved by full-time health departments covering the whole state, the Commission invited Dr. A. C. Offutt, State Health Commissioner to come to our meeting as a resource person on this subject. He suggested by consolidating the present 101 departments into a significantly smaller number thus broadening the tax base, there would be enough money to support a good local health department for all areas. In this way activities which now are being poorly and partially done by volunteer persons would receive the attention their importance deserves.

Many problems can be seen when such a program is considered. But the Commission received the proposals with general approval. This subject should be investigated further and helped in its planning by organized medicine.

Pollution: The subject of solid-waste disposal and air and water pollution were discussed at length, also with Dr. A.C. Offutt, State Health Commissioner. The problems of pollution must be kept in realistic perspective in order for society to solve them. With all the groups who are interested in pollution, doctors are and should be the key and most influential. Organized medicine should be active in composing legislation in this field.

Finally, it is suggested that at least four subjects should be on the agenda of the Commission on Public Health for next year:

(1) Activity in occupational health. This subject was not covered this last year. Among many subjects which could be covered are employment of handicapped, noise standards, alcoholism in industry, and free choice of physicians in industrial injuries.
(2) Continuing interest in and support of the anti-pollution program and active participation and legislation on the subject.
(3) Venereal disease control.
(4) Improvement of local health departments in the state.

JAMES B. JOHNSON, M.D.
Chairman
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AMADEO F. GREGOLINE, M.D.
HENRY G. NESTER, M.D.
WILLIAM K. NEWCOMB, M.D.
WARREN L. NICCUM, M.D.
THEODORE C. PERSON, M.D.
JAMES S. ROBERTSON, M.D.
EARLE U. ROBINSON, M.D.
WYANT J. SHIVELY, M.D.
WILLIAM SIGMUND, M.D.
WILLIAM C. VON DER LIETH, M.D.
LOWELL J. HILLIS, M.D.

Public Information

HOUSE ACTION: Referred to Board of Trustees. Details of funding waiting room display kits to be determined.

The Public Information Commission met on two occasions this year to consider routine and new business. The highlights of these meetings and the Commission's recommendations are as follows:

DRUG LITERATURE: Literature and information on this timely subject are available from the AMA. This fact was brought to the attention of the local county societies by the Commission, and this literature is recommended as a very valuable source of information.

TODAY'S HEALTH GUIDE: This AMA book is felt by the Commission to be quite well written for lay readers. It is felt that it is excellent medical reference material. It has been recommended to the local county medical societies that they might well spend the money to stock school and public libraries with this book and so make a good public relations gesture locally.

WAITING ROOM DISPLAY KITS: The Commission has initiated this new program but, as of this writing, the final, complete program has not been formally presented to the Board of Trustees nor has any funding for this program been given. It is hoped that by the end of the present year, or the beginning of 1972 at the latest, the Board of Trustees will have had this program for their consideration. The Commission feels that a continuing service to all ISMA physicians might well be periodic distribution of placards, suitable for display in the physician's waiting room and containing subject material explaining organized medicine's views on medical, social, and economic problems.

PHYSICIAN LIABILITY BOOKLET: A booklet concerning the liability of the physician was considered by the Commission for distribution to every ISMA physician. The Commission feels that if the cost estimates are favorable, this booklet should be distributed to every physician currently in the state and to every new member of ISMA thereafter.

1971 JOURNALISM AWARDS AND PHYSICIAN'S COMMUNITY SERVICE AWARD: Nominees and applications for these awards were screened by the Commission and selections for each category were made by the Commission. The Commission was gratified by the excellent response of the many people who submitted material for consideration for these awards. The material submitted was excellent in all cases. The increase in the number of nominees and applicants over last year was felt to be due in great measure to the added help given by each member of the Board of Trustees in distributing the information about these awards in their individual districts. The Commission also felt that distribution of news of previous winners to the various media helped in gaining more applicants. The Commission recommends to future Commissions that this method of application distribution be followed in subsequent years.

ISMA FILES ON PHYSICIAN'S ACTIVITIES: The Commission feels that these files should be updated, especially as to the physician's extra-curricular, public service activites. The Commission feels that they should author a questionnaire to be mailed to each ISMA active

member. The Commission recommends that this project be undertaken as a new project for a future Commission.

HINTS ON HEALTH: A column on health matters was prepared and distributed to daily and weekly newspapers in Indiana.

FRED W. DAHLING, M.D.
Chairman
WILLIAM B. CHALLMAN, M.D.
THOMAS O. MIDDLETON, M.D.
LOUIS H. BLESSINGER, M.D.
KENNETH D. SCHNEIDER, M.D.
RICHARD S. BLOOMER, M.D.
ROBERT W. HARGER, M.D.
PAUL BURNS, M.D.
SEYMOUR W. SHAPIRO, M.D.
REEVE PEARE, M.D.
BARBARA BACKER, M.D.
HARRY G. BECKER, M.D.
VICTOR JOHNSON, M.D.

Special Activities

HOUSE ACTION: Approved.

During the 1970-71 year the Commission on Special Activities concerned itself with some old and some new problems. The matter of the orientation program for new members was further discussed. The prevailing apathy of physicians with regard to the role and functions of the Association and, especially, the apparent lack of interest in active participation in the affairs of the Association, present serious obstacles to the introduction of an effective orientation program. An alternative possibility to presenting an orientation program at the local level was suggested and explored. It consists in presenting an orientation program to medical students through the facilities of the Indiana University School of Medicine to which Dean Irwin responded favorably. Details are being worked out.

The Commission also devoted much time to the issues of drug abuse and alcoholism. This subject was discussed in one of the Commission's meetings with Dr. William Murray, State Commissioner of Mental Health. The Commission passed a recommendation that ISMA "lend full support to efforts to study drug abuse and drug abuse education, help determine needs, develop programs with the State Board of Health and the Department of Mental Health, and make recommendations to the next session of the Indiana General Assembly."

Finally, the Commission concerned itself with the question of the doctor shortage in rural areas. Mr. Philip Willkie, president of Southern Indiana, Inc., reported on his ideas. The matter is to be discussed further.

HANUS J. GROSZ, M.D., *Chairman*
MARVIN F. PRIDDY, M.D.
CHARLES L. MILLER, M.D.
WILLIAM H. GARNER, JR., M.D.
JOHN C. LINSON, M.D.
FRED E. HAGGERTY, M.D.
ADOLPH WALKER, M.D.
FRED POEHLER, M.D.
EVERETT DONNELLY, M.D.
PETER E. GUTIERREZ, M.D.
ROBERT P. ACHER, M.D.

Voluntary Health Agencies

HOUSE ACTION: Ordered filed for information.

The members of the Commission appointed by the President for this year are as follows:

NORMAN R. BOOHER, M.D., *Chairman*
LOWELL W. PAINTER, M.D., *Vice-Chairman*
ROBERT H. RANG, M.D., *Secretary*
ALBERT RITZ, M.D.
T. A. NEATHAMER, M.D.
HARRY R. BAXTER, M.D.
WILLIAM G. BANNON, M.D.
WAYNE ENDICOTT, M.D.
HAROLD L. MILLER, M.D.
WALFRED A. NELSON, M.D.
LLOYD L. HILL, M.D.
RICHARD WILLARD, M.D.
FRANK J. McGUE, M.D.
MAX HOFFMAN, M.D.
CHARLES RUSHMORE, M.D.

The chairman attended the organizational meeting held by the president in November for all Commission chairmen, and the first meeting of the Commission on Voluntary Health Agencies was held on the 23rd of January, 1971.

Because of the illness of Doctor Norman R. Booher, the appointed Chairman, Doctor Scamahorn temporarily presided at this meeting, and the members of the Commission elected Doctor Lowell Painter Vice-Chairman, and Doctor Rang was elected Secretary-Treasurer.

The annual report for 1970 was reviewed and the action of the House of Delegates on this report was presented.

A review of the effect of the distribution of the annual placard (reproduced in miniature by the Indiana Tuberculosis Association) was reviewed and enthusiastic responses were noted from the governor, the mayor of Indianapolis, the State Board of Health, and the Indiana Manufacturers' Association. It was noted with especial enthusiasm that the Manufacturers' Association had asked for more than two thousand placards to be distributed to their member industries.

The Commission agreed to sponsor a scientific program for the fourth straight year before the annual meeting of the Indiana Public Health Association in April.

A dinner for the members of the Commission present, and their wives, was held at Kendall Inn, Saturday night, January 23.

On Sunday morning, January 24, the Commission reconvened and met with the presidents and executives of all the voluntary health agencies with statewide programs in the State of Indiana at the headquarters building of the Indiana State Medical Association. The programs of every voluntary agency were reviewed by requiring each representative to speak. Some suggestions from these agencies were received, but the bulk of the comment was very complimentary to the work of the State Medical Association through this Commission. The comment was again repeated that it is very difficult for the voluntary agencies to get physicians to their meetings and to be active in their Board of Directors. This has been a derogatory comment on the part of these organizations as far as the ISMA is concerned for many years.

Dr. Byron L. Steger, chairman of program committee, was present, and with him plans were completed for the State Medical Association and the voluntary agencies to present a scientific program at the annual meeting of Public Health Association in Indianapolis on Thursday, April 22, 1971. As a gesture of goodwill, all the guests were invited to a buffet luncheon with the Indiana State Medical Association as host at noon.

The second and final meeting of the Commission was held on April 22. This day was begun with a breakfast, hosted by ISMA, at which the executives of voluntary agencies and the speakers were guests. A very spirited and helpful discussion ensued at this breakfast.

A scientific program was presented before the meeting of the Indiana Public Health Association, with Dr. Peter Petrich, president-elect of the Indiana State Medical Association; Dr. Eli Goodman, member of the Board of Trustees of the Indiana State Medical Association, and Dr. Thomas A. Neathamer, member of the Commission on Voluntary Health Agencies, as speakers. This program was an excellent one and was very well received by the audience.

After the scientific program, the Commission held a luncheon meeting at the Stouffer Inn and the critique of the program just presented was undertaken, with certain suggestions to improve it in a sub-

sequent year, if this program is to be continued. It is felt that next year's program should be a followup on the subjects of the speakers addresses this year, especially on physicians' assistants programs in Indiana and the well-baby clinic in Jeffersonville.

The work of the Commission during the year was reviewed in detail and the Commission authorized the distribution of the placards, listing the approved voluntary health agencies in the State for another year as of May 1st. The distribution of these placards was to follow a pattern similar to last year, with 2300 copies going to the Indiana Manufacturers Association and a wide distribution by the voluntary agencies themselves, plus distribution to all doctors of the state through the field secretaries. The news media and others are to be contacted as last year.

The members of the Commission voted unanimously to repeat the January meeting with the representatives of the agencies in January 1972, with the direction that the chairman request from the Board of Trustees of the Indiana State Medical Association that the general meeting on Sunday morning be expanded to not only the executive secretaries and presidents of the various voluntary health agencies but to ten lay volunteers from each of these agencies. This would entail the same type of agenda as presented in the past with a general discussion of all the programs of the voluntary agencies and those concerned with them in the ISMA, with the ten volunteers present to hear the discussion. This would entail furnishing some type of luncheon to this many additional individuals. It was also decided by the Commission that the Commission hold a business meeting on Saturday, preceding the Sunday meeting, beginning at 4:00 p.m. Wives of the Commission members would be extended an invitation to join them at 6:30 p.m. for dinner. A letter requesting an additional $500 over and above the usual budget has been directed to the chairman of the Board of Trustees and the Executive Committee.

The agencies approved by your Commission this year, under the same criteria as previously established, include:

American Cancer Society, Indiana Division
Indiana Society for the Prevention of Blindness
Indiana Society for Crippled Children and Adults, Inc.
Indiana Heart Association
The Arthritis Foundation
Mental Health Association in Indiana
Indiana Tuberculosis and Respiratory Disease Association
United Cerebral Palsy of Indiana
Indiana Chapter, National Multiple Sclerosis Society
Tri-State Epilepsy Association, Inc.

The Chairman would like to acknowledge his appreciation of the continued cooperation of the members of the Commission and especially would like to thank Dr. Lowell Painter who stepped into the leadership of the Commission during the illness of the chairman, and to Mr. Kenneth Bush who has remained a very stalwart helper in all of the activities of this Commission.

NORMAN R. BOOHER, M.D.
Chairman

Emergency Medical Services

HOUSE ACTION: Adopted.

The Commission has held two meetings and is planning another meeting following a report of the results of a survey on emergency room equipment in all Indiana hospitals, and the staffing of these hospitals. The survey was mailed to all hospital chiefs of staff and hospital administrators, and copies sent to all county medical societies for their information on June 9, 1971.

It is planned that the results of the survey will be returned to all societies and hospitals, so that each hospital in Indiana will have an opportunity to compare itself to other hospitals of similar size. If these results are available by the time of the annual convention, they will be included as an addendum report to this report.

The Commission notes that in data collected by the Indiana Hospital Association and the Indiana State Board of Health, such information is not available. Results will also be made available to the Governor's Advisory Committee on Emergency Medical Services.

Following are some of the points discussed at the meeting of April 7 which the Commission feels should be reported to the House of Delegates:

(1) The Indiana Emergency Medical Service Plan, as formulated by the Governor's Advisory Committee, is now five years old.

(2) Concerning hospital statistics, Robert L. Rogers, Director of the Hospital and Institutional Services Division, Indiana State Board of Health, has as complete information as anyone in Indiana.

(3) The Commission on Emergency Medical Services of Indiana State Medical Association could avail itself of this data and interpret the material to the county societies.

(4) A study, known as the Hoffman Report, is now being completed at Marion County General Hospital on emergency medical care and the results of this study will be made available to the Commission.

(5) Many organizations proceeding in different directions, seeking solutions to emergency medical service problems, are being brought into closer cooperation through the National Research Council.

(6) The American Medical Association accepted in March an emergency medical service plan which is almost identical to the Indiana plan.

(7) The Commission was urged to direct its efforts in achieving the goals of the Indiana Emergency Medical Services plan. These are listed as "Recommendations for the Emergency Medical Services Program," pages 4-8 in the Plan.

(8) Training courses for ambulance attendants and ambulance institutes were conducted by the Indiana State Board of Health in various locations throughout Indiana.

(9) Emergency Medical Service plans should not only be developed by counties but should extend through the medical society districts.

H.B. 1753, introduced in 1971 in the General Assembly, was followed closely by the Commission. The proposed law was designed to accomplish the following: 1) adopt the uniform ordinance of the National Academy of Science governing licensure and operation of ambulance service; 2) establish an essential equipment list for ambulances; 3) set forth training programs for ambulance personnel; 4) extend Good Samaritan Law to all personnel involved in roadside care of accident victims. The Board of Trustees supported the bill.

The Commission was active in working for its passage, but the bill failed because of resistance by the State Highway Commission and private ambulance owners, who handle most emergency ambulances in small areas.

Plans are now being made by the Legislative Commission of the Association and the Indiana State Board of Health to introduce another bill which will, hopefully, be considered and passed by the 1972 General Assembly.

Among several points covered at the February 7 meeting of the Commission were the following, which the Commission

feels should be included in this report for the information of ISMA members.

(1) The Highway Safety Act was passed in 1966 and it was felt that the area of emergency medical services was in need of a vast overhaul. Adequate first-aid training for personnel was very inadequate.

(2) Responsibility to develop better emergency medical services was assigned, in most states, to the Boards of Health. In Indiana it is the Indiana State Board of Health.

(3) The major objective of the emergency medical services plan is to transport the victim of an accident as quickly as possible to a location for definitive medical care, since 80% of deaths are during the period of time from the location to the source of care.

(4) *ISMA is urged to take a leadership role in the organization of Emergency Health Service Councils county-by-county. These councils could inventory their present services and recommend changes. The ISBH is in a position to assist these locally planned councils.*

(5) These councils do not have to await formation of Comprehensive Health Planning Councils but could easily become a subsection of such councils, once they are formed.

(6) ISBH is requesting $2 million for the next year to effect stimulation and operation of the emergency councils.

(7) The entire area of emergency medical services will be a continuous process of innovation and change.

CLEON M. SCHAUWECKER, M.D.
Chairman
JOHN G. SUELZER, M.D.
RAYMOND W. NICHOLSON, M.D.
NEAL E. BAXTER, M.D.
DONALD R. SHORTRIDGE, M.D.
CHARLES A. RAU, M.D.
WILLIAM W. DRUMMY, M.D.
HOWARD WILLIAMS, M.D.
JAMES W. KRESS, M.D.
FORREST J. BABB, M.D.
ROBERT M. BROWN, M.D.
JOHN S. FARQUHAR, JR., M.D.
JAMES D. FINFROCK, M.D.
WILLIAM F. KERRIGAN, M.D.
WILLIAM F. NOWLIN, M.D.

Governmental Medical Services

HOUSE ACTION: Referred to Board of Trustees for continued action.

This Commission has met on several occasions during 1970-71 for the purposes of considering the business of the Medical Association in regard to state and federal and, in some areas, county involvement of the physicians of Indiana in medical services in these areas.

The CHAMPUS dependents medical care program was reviewed on a number of occasions as well as frequent telephone conferences to adjudicate questionable claims. The claims were satisfactorily processed and it is our impression that the OCHAMPUS headquarters in Denver was satisfied with our decisions and that the physicians concerned on the claims, except in probably one instance, concurred with the Commission's deliberation. I believe that the satisfaction of the physicians and also the fiscal agent was a direct result of this Commission's deliberations in 1970 where the usual and customary basis was adjusted to reflect the increase in fees in the state of Indiana.

Consideration of a relative value schedule for the use of the physicians of Indiana in determining fees and also allowing the various review commissions of the state and county societies to deliberate with fiscal agents was discussed. It is felt that, before a hard and fast recommendation can be made to the House of Delegates on this matter, some way must be found to determine what the usual and customary and reasonable fees are in the State of Indiana. This information probably could be obtained from insurance companies but they are reluctant to disclose their basis for determining indemnities. A postal canvass and survey of the physicians of Indiana is recommended to determine what their usual and customary and reasonable fees are in geographic areas. No cost estimate is available for this survey but it would certainly be most helpful in future decisions. If the survey is deemed unnecessary, it was the feeling of this committee that the 1969 California Relative Value Schedule is quite complete and has, in most areas, a reasonable unit value for services rendered. If the California Relative Value Schedule is used for Indiana, some modifications might be necessary in a few of the specialty areas with regard to the unit value, and an appropriate conversion factor could then be applied by the physicians in various geographic areas or throughout the state depending upon their requirements.

Another area of concern over the year was another way of delivering medical care to the indigent. The present Medicaid program on a fee-for-service basis is apparently fairly satisfactory to the Welfare Department for the cost of medical services per indigent person is now only $1 more per month than it was in 1968 when the original budget was conceived. The high cost of the program (1970—$57,000,000), however, was due to the twofold increase of indigent persons covered under the program. The Welfare Department feels, however, that they might economize further with total medical care under a foundation-type of medical service. The Welfare Department might be willing to allow a state or county medical foundation to completely administer and be the fiscal agent for the medical care of a certain geographic group of people and, in return, would pay what would amount to a premium per person covered under the plan. This will have to be considered at future meetings and also the feelings of the Board of Trustees must be considered as well as where other information is available from other Commissions.

The present proposed legislation in the U.S. Senate and Congress in regard to medical care for the indigent alone, or for the total population, has somewhat limited our ability to make a decision with regard to medical care for the indigent in the state of Indiana. We felt that to set up any plan or proposal at this time which might be negated in a year or two by a federal plan would only confuse the issue. Although the Welfare Department was quite pleased with the Medicaid program in our conferences with their chief administrator, Mr. William Sterrett, there were some instances—probably of overutilization—referred to the local county societies to be deliberated and some action taken. It would be our impression that satisfactory conclusions have been reached in all areas.

Also, with regard to Medicaid, there were lengthy meetings with the Blue Shield officers as well as an extensive tour of the Blue Shield facilities. We felt that we could better understand the fiscal problems involved in the complicated administration of the Medicaid program if we viewed their operation. A lengthy meeting was arranged and it seemed quite satisfactory. Blue Shield at the present time is processing Medicaid claims at 25% less than they had at the beginning of 1970. This is a low per-claim cost of $1.20, but the cost is diluted by the number of drug claims which require minimal processing. Blue Shield's regular business costs $3.40 to process and Medicare $3.10 to process. In 1970 an excess of two million claims were processed for an average of 41,000 Medicaid claims per week. The administrative efficiency now allows payment of 75% of these claims within two weeks. The major problem is in delaying payment, in determining patient eligibility, and also in erroneous completion of the claim forms in the physician's office. Claims review is required in a small percentage and, as

noted above, only a few instances of over-utilization seem to occur. The Welfare Department is attempting to improve the basis for determining fees to July of 1970 as compared to the present 1969 basis at the 75th percentile.

The processing of a claim requires many steps, including microfilming, preparing tape for a computer and then on-line transmission to a computer processing center in Texas with a return the following day. Claims then are placed for payment shortly thereafter allowing for the rapid deliberation. With the 15 or 25% of claims that need to be rechecked and doctors' offices contacted for further information, the committee felt that some improvement could be made in this area to allow less handling. Possibly a common language could be used at the origin in the physician's office as well as through the computerization and payment of the claim. Here again a relative value schedule or procedural terminology book in each office and which is being used by the computer operator would speed up the processing and reduce the number of errors. Another concept considered by the Commission would be to place computer terminals of origin in county society offices or even having on-line computer mechanisms in the physician's office or if a group of physicians are together in a clinic or medical building with direct access to the main computer facilities. The cost of such an operation might be excessive to institute but possibly in the long-term function would reduce operative costs and speed up payment of claims.

A utilization review could be built into such a computer operation to allow for immediate review and possibly allow for fewer claims reviewed. If the mechanization or computerization of such a system originating in a county or a group of physicians' offices is not feasible, then possibly the distribution by the fiscal agent of Medicaid to the physicians' offices of a procedural terminology book with code numbers might enhance the processing. Since the claim forms need to originate in the physician's office, it would be no more of a problem for code numbers to be applied by the physician's employee to each procedure and diagnosis which then will allow one less step by the fiscal agent. This is time-consuming when 41,000 claims per week are being considered and, with the present rate of 69,000 claims per week with future increases, some simplification of the system must be found.

The Blue Shield has maintained that 70% of the physicians of Indiana have submitted Medicaid claims in 1970. On closer scrutiny and not being able to obtain exact breakdown information, the Commission determined that approximately 3% of the physicians of Indiana submitted claims that total 50% of the dollars paid to physician providers. In this instance these physicians were located in areas of high indigent population. Therefore, it would seem that the physicians of Indiana have cooperated with the Medicaid program as they wish with free choice of patient on their part. It also would seem that the indigent patient is receiving good medical care at a cost that is basically high, but which is a total-care plan. In discussing with other insurance companies the economics of a total-care plan, it would seem that the State of Indiana's present policy is fairly economical. Albeit the hospitals and providers of facilities are receiving total reimbursement of their fees but the physician is still receiving compensation on the basis of outdated fee schedules at the 75th percentile. This, of course, is partly regulated by the federal government and no local changes can be made. The Welfare Department, on the other hand, is attempting to improve this basis, realizing that Indiana physicians are personally involved in the care of their patients and also the cost of that care. One area we noted in which the cost might be reduced and errors avoided would be in a more efficient administrative processing of the claims either by local computer access or a coded relative value schedule.

The budget allowance for Medicaid for fiscal 1971 is $87 million. This is, then, an increase of 65% over 1970 and reflects an anticipated increase in eligible indigents, again probably 65% over 1970. This eligibility is a direct result of federal action and the local Welfare Department is helpless in two areas; namely, the inability to process as rapidly as they wish all supposed indigents and also the activities of welfare supporters in reducing the requirements for eligibility. The State of Indiana in 1970 was well below the local average of the United States in indigent persons. The national average is in the area of 6% as of January 1971, while Indiana reflected a 2.6% of the population. No plateau is in sight as the number continues to increase. The total wefare budget in the State of Indiana is in excess of $500 million and approximately $180 million is required from state funds.

The Welfare Department feels that the Blue Shield organization has been an adequate fiscal administrator of the Medicaid program, due to the fact that the costs of administering have been reduced gradually over 12 months and anticipated reductions are looked for in the future. The Welfare Department would consider a change only if the costs can be met or reduced even further.

Another area of deliberation for this Commission during 1971 was the Medicare program of care for the elderly and it would seem that this program is fairly well established, is regulated completely by the federal government, and local jurisdiction is minimal. Blue Shield processes these claims as well, except for the subsidiary benefits that the claimant might have. If it is Blue Shield subsidiary, this is processed under a separate division of Blue Shield. All claims must be processed through Baltimore's Social Security office to determine what deductibles the patient is still responsible for.

In conclusion, the Commission has met a number of times during the year and deliberated the above topics. Whether anything can be instituted—such as the relative value schedule for the physicians of Indiana or the use of a computerized local access system for Medicaid, or other forms-processing, or even the use of a procedural terminology with code numbers in the physician's office to facilitate Medicaid processing—this will only be known in the future.

I wish to thank the members of the Commission for their devotion to their work and also for the stimulating discussions in the forming of opinions that have been forthcoming.

It was a pleasure to serve as chairman of this commission during the year and I respectfully submit this report.

MICHAEL J. MASTRANGELO, M.D.
Chairman
COLA K. NEWSOME, M.D.
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Legislation

HOUSE ACTION: Commission on Legislation authorized to introduce Medical Disciplinary Act in 1972 General Assembly after finalization by Legal Department of ISMA. Report adopted as amended.

Your Commission on Legislation reports as follows:

During the 1971 General Assembly your commission held weekly meetings to study proposed legislation and to promulgate courses of action to be followed by our registered lobbyists.

Many bills were introduced in both the House and Senate having medical interest and in the course of the legislative procedure 14 Senate Enrolled Acts and 16 House Enrolled Acts became law. In all, your commission reviewed more than 200 bills and resolutions.

It will be the purpose of this report to point out highlights of these new laws, to comment on some which did not pass and to mention legislation we should consider for the next session which will be in January 1972.

It should be pointed out that changes have taken place within the workings of the Indiana General Assembly which will have a definite effect on the pattern of lobbying in the future.

The first is that annual sessions will be held. The second is the creation of the Legislative Council. These two changes mean that our future lobbying efforts will have to be a year round affair rather than once every two years.

The existence of the Legislative Council mitigates the role of the individual Legislator in introducing bills. In this new arrangement bills are to be put through the Legislative Council first before they are pre-filed, introduced and considered on the floor.

Our first consideration will be a rundown on the new legislation. We will take the Senate Enrolled Acts First:

S.E.A. 2 (Establishes Commission on Higher Education)—This new commission will have the power to review both budget and curriculum of the several state supported post-high-school educational institutions. Since medical education is included in this category, it can be seen that future acts of the Commission could have a tremendous impact on decisions regarding the course medical education may take in Indiana.

S.E.A. 19 (Reporting Blindness and Visual Impairment)—This amends a 1949 law which requires every licensed physician to report to the State Board of Health cases of serious visual impairment under penalty of a $25 fine for failure to report. The new law includes optometrists among those having to report.

S.E.A. 148 (New Nursing Regulations)—In effect, this is a brand new nursing law. It differentiates between registered nurses and licensed practical nurses and sets forth the qualifications for both.

S.E.A. 164 (Community Health Centers)—Provides for funding of local community mental health centers through taxation at the local level at the rate of four cents on every $100 of taxable property.

S.E.A. 221 (Hospital Admission of the Mentally Ill)—Updates the proceedings for the admission of the mentally ill to psychiatric hospitals. (Physicians concerned should read the provisions in detail).

S.E.A. 290 (Drug Abuse Omnibus Bill)—There were a number of bills having to do with drug abuse and drug education introduced in the 1971 session. In general, they were lumped together into this one bill. It provides for methadone treatment for addicts under controlled rehabilitative programs and has a number of other features, all of which will be under the supervision and control of the Indiana Department of Mental Health.

S.E.A. 296 (New Positions in Department of Mental Health)—This defines responsibilities and adds new classifications in the department of mental health, and maintenance of patients in psychiatric hospitals.

S.E.A. 309 (Narcotic Drugs)—This removes marijuana from the list of narcotic drugs and, in some instances, redefines and updates the general definitions of the narcotic drugs.

S.E.A. 311 (Hospital Committee Records Confidential)—Hereafter, all members of duly constituted hospital review committees (e.g. tissue committee) have absolute immunity from civil liability. This immunity also applies to committee reports, records and recommendations made to the governing board of the hospital.

S.E.A. 315 (Dangerous Drugs)—This is a companion measure to S.E.A. 309 (see above) which makes marijuana a "dangerous drug" rather than a "narcotic drug." There is also in this bill some redefinition of those drugs classified as "dangerous."

S.E.A. 388 (Fort Wayne TB Hospital)—Redefines the population levels pertinent to this facility and sets up the board of managers for the facility.

S.E.A. 459 (Chemical Test for Intoxication)—This is a revision of the state's implied consent law; adds drugs and also adds "probable cause." Does not change alcohol content level.

S.E.A. 470 (Regulation of the Practice of Physical Therapy)—All this bill does is to provide for a "physical therapist's assistant."

S.E.A. 601 (Radiation Control)—All this does is to provide regulations governing microwave ovens. It has nothing to do with the practice of radiology.

H.E.A. 1102 (Blood Is a Service)—This was a major legislative victory for ISMA and the allied health professions and hospitals. In response to the ISMA House of Delegates' 1970 mandate, your commission on legislation actively supported this bill which makes blood, blood products, as well as other human tissue, a service and not a product and therefore not warrantable, which should release doctors, hospitals, blood banks, donors and others concerned from liability in the event that a person suffers an untoward result from a transfusion or transplant.

H.E.A. 1127 (Rehabilitative Services for the Multiply Handicapped)—This is an initial step which, it is hoped, will lead to a strong program in Indiana. Token appropriations were provided.

H.E.A. 1128 (Immunization of Children)—Adds to the existing law the immunization for "German measles" and tests for Sickle cell anemia.

H.E.A. 1129 (TB Skin Tests)—Requires children to be given TB skin tests within 30 days of enrollment in school in kindergarten or first grade.

H.E.A. 1154 (Renal Disease)—Under this bill, the Legislature appropriated $500,000 for the biennium to cover renal dialysis. Another victory—as the House of Delegates adopted a resolution requesting this law.

H.E.A. 1176 (Setting Salaries of Board of Health Personnel)—This bill in its original form met strong opposition from your ISMA because the bill would have given to the county council the power to set ALL local health department salaries. As amended, the county council has power over the salaries of only the clerical personnel in a county health department, not the professional personnel.

H.E.A. 1215 (Accreditation of Private Schools)—All private vocational schools in the state of Indiana must be accredited and meet state standards. This should eliminate fly-by-night schools "guaranteeing" jobs for students who enroll in their ancillary medical training programs.

H.E.A. 1260 (Foreign Physicians)—A book could be written on the ISMA activities in connection with this subject. ISMA members are strongly urged to read the text of this Act. A waiver clause, that did not exist in the laws before, now gives the Indiana State Board of Medical Registration and Examination the right to waive certain requirements when an individuals' credentials warrant this.

H.E.A. 1309 (New County Hospital Law)—This is a complete recodification of the state's county hospital laws, with considerable modernizing. The bill repeals all existing county hospital laws. (Your hospital administrator should have a copy of this new law which you may care to review in detail.)

H.E.A. 1347 (Criminal Sex Deviation)—This bill adds a new chapter to Indiana law to provide for outpatient commitment of persons not convicted of, nor charged with, nor on probation for, commission of a violent sexual crime or a sexual crime

against someone under age 16. (Physicians concerned should refer to the text of the law.)

H.E.A. 1430 (Seven Regional Medical Centers)—As mandated by the 1970 House of Delegates, your Commission on Legislation supported this bill which establishes the Indiana Statewide Medical Education System.

H.E.A. 1436 (Medical Advisory Commission)—Adds an optometrist to the medical advisory commission on driver licensure of the Indiana Bureau of Motor Vehicles.

H.E.A. 1551 (Control of Phosphates)—Due in part to strong support from the ISMA, Indiana became the first state to put rigid controls on sale and use of detergents containing phosphate compounds. It reduces the content to 12% by weight or volume after Jan. 1, 1972 and 3% after Jan. 1, 1973.

H.E.A. 1679 (Health Officer Subpoena Powers in Ordering Autopsies)—In effect, this bill strengthens the hand of the local health officer in getting valid information as to the cause of death in questionable cases or in the case of the stillborn.

H.E.A. 1719 (Good Samaritan)—In this law the General Assembly adopted the law of the State of North Carolina which does not specify occupations or professions or competency of individuals rendering aid at the scene of an emergency and holding all such persons free from liability except for gross negligence.

The second phase of this report has to do with some of the legislation that did not pass.

Of greatest concern was the emergency ambulance bill which failed primarily because of the $5 million per annum price tag. There were some other factors, such as last minute opposition from the funeral directors and the volunteer firemen groups, particularly those within the Indianapolis metropolitan community.

Also of concern was the defeat by ISMA and other groups of S.B. 120, which was a workman's compensation measure. In its original form it granted an employe the right to choose his own physician, dentist or podiatrist after 60 days. The bill was later amended to include "chiropractors" and was further amended to define a chiropractor as a physician. The bill barely squeaked through the House and Senate, but was vetoed by the Governor. The veto was then sustained in the Senate and the bill was lost. This bill represents what we face in almost every session—pressure from the chiropractors to improve their lot.

Although the House of Delegates mandated that ISMA support legislation for the control of the environment, your Commission on Legislation had to take a position of opposition to the major bill as introduced—The Environmental Management Act—because it removed the environmental control functions from the Indiana State Board of Health and created a super board with "outlandish" salaries and awesome powers. There was nothing wrong with the intent of the bill, only with the method and implementation.

A bill for creation and regulation of physicians' assistants was introduced in the Senate, but at our request it was held in committee and allowed to die because of problems of definition and some opposition that arose from some unexpected quarters.

As in past sessions, a bill to create the position of medical director in the Department of Corrections failed.

Also failing was the safety glazing bill, but we have information that this may be changed by a new regulation in the state building code and may not require a new law.

As to the future, your Commission has been meeting this summer and looks forward to the reintroduction of the emergency ambulance bill in the next session of the General Assembly.

The commission also has under consideration measures having to do with environmental control, medical discipline, changes in the medical practices act and will be reviewing other measures affecting the practice of medicine and the delivery of health care as they arise.

Medical Disciplinary Act. In accordance with the action of the House of Delegates in 1970, your commission has studied medical disciplinary procedures and has prepared a bill for introduction in the 1972 session of the General Assembly. This bill, as prepared, is taken from the Washington State Medical Association bill. That association reports that it has had this procedure in operation for many years and considers it very successful. Before introducing this bill, however, we desire the approval of the House of Delegates. The proposed bill follows:

Section 1. Declaration of purpose. This chapter is passed:

(a) In the exercise of the police power of the state to protect public health, to promote the welfare of the state, and to provide an adequate public agency to act as a disciplinary body for the members of the medical profession licensed to practice medicine, surgery or obstetrics in this state;

(b) Because the health and well-being of the people of this state are of paramount importance;

(c) Because the conduct of members of the medical profession licensed to practice medicine, surgery or obstetrics in this state plays a vital role in preserving the health and well-being of the people of the state; and

(d) Because the agency which now exists to handle disciplinary proceedings for members of the medical profession licensed to practice medicine, surgery or obstetrics in this state is ineffective and very infrequently employed, and consequently there is no effective means of handling such disciplinary proceedings when they are necessary for the protection of the public health.

Section 2. Definitions. Terms used in this chapter shall have the meaning set forth in this section unless the context clearly indicates otherwise:

(a) "Board" means the medical disciplinary board.

(b) "License" means a license to practice medicine, surgery or obstetrics in this state as provided in Acts 1897, Ch. 169, Section 1, page 255 et seq.

(c) "Members" means members of the medical disciplinary board.

(d) "Secretary" means the secretary of the medical disciplinary board.

Section 3. "Unprofessional conduct." The term "unprofessional conduct" as used in this chapter shall mean the following items or any one or combination thereof:

(a) Conviction in any court of any offense involving moral turpitude, in which case the record of such conviction shall be conclusive evidence;

(b) The procuring, or aiding or abetting in procuring a criminal abortion;

(c) Fraud or deceit in the obtaining of a license to practice medicine;

(d) All advertising of medical business which is intended or has a tendency to deceive the public or impose upon credulous or ignorant persons and so be harmful or injurious to public morals or safety;

(e) The impersonation of another licensed practitioner;

(f) Habitual intemperance;

(g) The use or prescription for use of narcotic drugs in any way other than for therapeutic purposes;

(h) The offering, undertaking or agreeing to cure or treat disease by a secret method, procedure, treatment, or medicine, or the treating, operating, or prescribing for any human condition by a method, means, or procedure which the licensee refuses to divulge upon demand of the board;

(i) The wilful betrayal of a professional secret;

(j) Repeated acts of immorality;

(k) Repeated acts of misconduct in the practice of the profession;

(l) Repeated acts of malpractice;

(m) The acceptance of any rebate or other compensation for any referral of a patient;

(n) Aiding or abetting an unlicensed person to practice medicine; or

(o) Declaration of mental incompetency by a court of competent jurisdiction.

Section 4. Board created-Composition-Legal advisor. There is hereby created the "Indiana State Medical Disciplinary Board," which shall be composed of one holder of a valid license to practice medicine, surgery or obstetrics from each federal congressional district now existing or hereafter created in this state. The board shall be an administrative agency of the state of Indiana. The attorney general shall be the advisor of the board and shall represent it in all legal proceedings.

Section 5. Election of Members. Members of the board shall be elected by secret mail ballot by the holders of licenses to practice medicine, surgery or obstetrics residing in each federal congressional district and shall hold office until their successors are elected and qualified. Members from even-numbered federal congressional districts shall be elected in even-numbered years and members from odd-numbered federal congressional districts shall be elected in odd-numbered years.

Section 6. Nominations. Nominations to the board may be made by petition signed by not less than twenty-five license holders residing in the nominee's district, and shall be submitted to the board at least four weeks prior to the date of the election. Votes cast for license holders not so nominated shall be valid.

Section 7. Date of election-Commencement of term. The election shall be held in September and shall be conducted in accordance with rules and regulations adopted by the board under the rule-making power hereinafter provided for. Terms of office of members shall commence on October 1st.

Section 8. Vacancies. Any vacancies in the board shall be filled by the governor by appointment from the federal congressional district in which the vacancies occurred, and a member appointed to fill a vacancy on the board shall serve until the naming of his successor in the next district election and until his successor takes office on the October 1st following the election.

Section 9. Removal of members. Any member of the board may be removed by the governor for neglect of duty, misconduct or malfeasance or misfeasance in office, after being given a written statement of the charges against him and sufficient opportunity to be heard thereon.

Section 10. Compensation and reimbursement of members. Members of the board shall be paid twenty-five dollars per diem for time spent in performing their duties as members of the board and shall be repaid their necessary traveling and other expenses while engaged in business of the board, with such per diem and reimbursement for expenses to be paid out of the general fund on properly approved vouchers: *Provided*, That the amount for expense will not be more than fifteen dollars per day, except for traveling expense which shall not be more than eight cents per mile.

Section 11. Territorial scope of operations. The board may meet, function, and exercise its powers at any place within this state.

Section 12. Organization of first board. The first board shall be organized in this manner: Within ten days after the effective date of this chapter the governor shall appoint five holders of licenses to practice medicine, surgery or obstetrics in this state to serve as members of a temporary commission which shall, within ninety days thereafter, organize and hold the election to name the first members of the medical disciplinary board. The temporary commission shall adopt such rules and regulations as it deems necessary to govern the holding of the first election. After the election is completed and the first members of the board have qualified and taken office, the temporary commission shall be abolished and all of its records shall be turned over to the board.

Section 13. Officers-Meetings-Quorum. The board shall elect from its members a chairman, vice-chairman, and secretary, who shall serve for one year and until their successors are elected and qualified. The board shall meet at least once a year or oftener upon the call of the chairman at such times and places as the chairman shall designate. A majority of the board members shall constitute a quorum to transact business.

Section 14. Immunity from suit. Members of the board shall be immune from suit in any action, civil or criminal, based upon any disciplinary proceedings or other official acts performed in good faith as members of such board.

Section 15. Powers and duties. The board shall have the following powers and duties.

(a) To adopt, amend and rescind such rules and regulations as it deems necessary to carry out the provisions of this chapter;

(b) To investigate all complaints and charges of unprofessional conduct against any holder of a license and to hold hearings to determine whether such charges are substantiated or unsubstantiated;

(c) To employ necessary stenographic or clerical help;

(d) To issue subpoenas and administer oaths in connection with any investigation, hearing, or disciplinary proceeding held under this chapter;

(e) To take or cause depositions to be taken as needed in any investigation, hearing, or proceeding.

Section 16. Complaints-Hearing committee. Any person, firm, corporation or public officer may submit a written complaint to the secretary charging the holder of a license to practice medicine, surgery or obstetrics with unprofessional conduct, specifying the grounds therefor. If the board determines that such complaint merits consideration, or if the board shall have reason to believe, without a formal complaint, that any holder of a license has been guilty of unprofessional conduct, the chairman shall designate three members to serve as a committee to hear and report upon such charges.

Section 17. Specification of charges. When a hearing committee is named, the secretary shall prepare a factual specification of the charge or charges of unprofessional conduct made against a license holder, a copy of which shall be served upon the accused, together with a notice of the hearing, said notice to be served in the manner and as provided in the Administrative Adjudication and Court Review Act of 1947 (Acts 1947, Ch. 365, Section 1 et. seq., as amended).

Section 18. Time, notice, of hearing. The time of hearing shall be fixed by the secretary as soon as convenient, but not earlier than thirty days after service of the charges upon the accused. The secretary shall issue a notice of hearing of the charges, which notice shall specify the time and place of hearing and shall notify the accused that he may file with the secretary a written response within twenty days of the date of service. Such notice shall also notify the accused that a stenographic record of the proceeding will be kept, that he will have the opportunity to appear personally and to have counsel present, with the right to produce witnesses and evidence in his own behalf, to cross-examine witnesses testifying against him, to examine witnesses testifying for him, to examine such documentary evidence as may be produced against him, and to have subpoenas issued by the board.

Section 19. Subpoenas-Contempt. Subpoenas issued by the board to compel the attendance of witnesses at any investigation or hearing shall be served and enforced in accordance with the provisions of Section 21 of the Administrative Adjudication and

Court Review Act of 1947 as amended (Acts 1947, Ch. 365, Section 21).

Section 20. Report of hearing. Within a reasonable time after holding a hearing under the provisions of Section 18, the committee shall make a written report of its findings of facts and its recommendations, and the same shall be forthwith transmitted to the secretary, with a transcript of the evidence.

Section 21. Hearing before full board. If the board deems it necessary, the board may, after further notice to the accused, take further testimony at a second hearing before the full board, conuducted as provided for hearings before the three man hearing committee.

Section 22. Basis for board's determination. In any event, whether the board makes its determination on the findings of the hearing committee or on the findings of the committee as supplemented by a second hearing before the board, the board shall determine the charge or charges upon the merits on the basis of the evidence in the record before it.

Section 23. Certificate of revocation or suspension-Reprimand. If a majority of the members of the board then sitting vote in favor of finding the accused guilty of unprofessional conduct as specified in the charges, or any of them, the board shall prepare written findings of fact and may thereafter prepare and file with the Clerk of the Circuit Court of the County in which such license was issued a certificate or order of revocation or suspension, and such Clerk shall record the same upon the margin of the record of such license, and a copy of said certificate or order shall also be served upon the accused. In the alternative, the board may reprimand the accused, as it deems most appropriate.

Section 24. Dismissal of charges—Exoneration. If the license holder is found not guilty, or if less than a majority of the members then sitting vote for a finding of guilty, the board shall forthwith order a dismissal of the charges and the exoneration of the accused. When a proceeding has been dismissed, either on the merits or otherwise, the board shall relieve the accused from any possible odium that may attach by reason of the charges made against him by such public exoneration as is necessary, if requested by the accused to do so.

Section 25. Revocation or suspension of license-Stay pending review. The filing by the board with the Clerk of the Circuit Court of the County in which such license was issued of a certificate or order of revocation or suspension after due notice, hearing and findings in accordance with the procedures specified in this chapter, certifying that any holder of a license has been found guilty of unprofessional conduct by the board, shall constitute a revocation or suspension of the license to practice medicine, surgery or obstetrics in this state in accordance with the terms and conditions imposed by the board and embodied in the certificate or order of revocation or suspension: *Provided,* That if the licensee seeks judicial review of the board's decision pursuant to the provisions of this chapter, such revocation or the period of such suspension shall be stayed and shall not be effective or commence to run until final judgment has been entered in any proceeding instituted under the provisions of this chapter and the licensee's judicial remedies exhausted hereunder.

Section 26. Contents of certificate—Recording. The certificate or order of revocation or suspension shall contain a brief and concise statement of the ground or grounds upon which the certificate or order is based and the specific terms and conditions of such revocation or suspension.

Section 27. Issuance of license after revocation or suspension. No license or any renewal thereof shall be issued to any person whose license has been revoked or suspended by the board except in conformity with the terms and conditions of the certificate or order of revocation or suspension, or in conformity with any order of reinstatement issued by the board, or in accordance with the final judgment in any proceeding for review instituted under the provisions of this chapter.

Section 28. Appeal from decision of board. The procedure for an appeal from any decision of the board shall be governed by Sections 14-19 of the Administratrix Adjudication and Court Review Act of 1947 as amended from time to time (Acts 1947, Ch. 365, Sections 14-19).

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Commission on Inter-Professional Relations

No report.

Resolution No. 71-1

Subject: ELECTION OF ALTERNATE DIRECTOR TO BLUE SHIELD

HOUSE ACTION: Not adopted.

WHEREAS, the Sixth District Medical Society has become aware that for continuity there should also be an alternate director for the director on the Board of Mutual Medical Insurance, Inc. (Blue Shield); and

WHEREAS, by having an alternate director it would serve to provide an educational experience for an individual who might at some time succeed to the directorship and also would permit the district to be represented in the absence of the regular director;

NOW, THEREFORE, BE IT RESOLVED, that Chapter XXXII of the Bylaws of the Indiana State Medical Association be amended by adding a Section 11 to read as follows:

"Section 11. It shall be the duty of each district medical society to select in any manner it chooses a member of its district to serve as an alternate director on the Board of directors of Mutual Medical Insurance, Inc. (Blue Shield). Said alternate director may be elected in the same year as the director and the results of such election shall be immediately transmitted to the Board of Trustees of the Indiana State Medical Association which will officially place said selected member in nomination for said Board of Directors. The term of office of the alternate director shall be the same as that of the director." and,

BE IT FURTHER RESOLVED, that the Indiana State Medical Association formally petition the Board of Directors of Mutual Medical Insurance, Inc. (Blue Shield) to change their bylaws, if necessary, to permit the election of an alternate director who shall have the full powers and duties of the director in the absence of the director but shall not have the power to vote but shall have the power of discussion when the regular director is present in the regular meeting of the directors.

Resolution No. 71-2

Subject: RESTRICTIVE COVENANTS — DECLARED UNETHICAL

HOUSE ACTION: Adopted substitute resolution for No. 71-2, as amended.

WHEREAS, restrictive covenants in contract clauses between groups or individual physicians tend to infringe upon the civil

rights of the individual when enforced; and

WHEREAS, more and more medical practice corporations and partnerships are being formed throughout the state of Indiana; and

WHEREAS, many physicians of great talent and ability have had to leave the area in which they practice because of such restrictive covenants; and

WHEREAS, each time a physician leaves his community, a gap appears in the medical care available to the citizenry; and

WHEREAS, the continued enforcement of such restrictive covenants tends to discourage the arrival of new physicians; and

WHEREAS, one of the purposes of organized medicine is to promote the health of the nation;

THEREFORE, BE IT RESOLVED that the Indiana State Medical Association opposes geographic restrictive covenant contracts between physicians and henceforth will consider such contracts entered into after the date of this resolution in violation of its purpose and, therefore, unethical;

BE IT FURTHER RESOLVED that the delegates to the AMA be instructed to present this resolution or a similar resolution of the same intent before the AMA House of Delegates at its next meeting.

Resolution No. 71-3

Subject: DECLARATION OF NON-PARTICIPATION POLICY

HOUSE ACTION: Referred to Board of Trustees for further study and action.

WHEREAS, the free enterprise, fee-for-service system of medical practice in the United States makes most efficient use of available medical personnel, encourages high quality medical care, and preserves the freedom of patient and doctor; and

WHEREAS, government intervention between practicing physicians and the patient historically removes responsibility from both parties and leads to decreasing quality of medical care; and

WHEREAS, the current proposals for Federal regimentation of medical care which are before the Congress (Senate Bill 3 and H.R. 7741) will result in total control of all patients and all doctors, with no free choice alternative; and

WHEREAS, the members of the Indiana State Medical Association wish to continue to provide medical services in the most efficient manner, retaining freedom of choice for physician and patient alike, and retaining mutual respect and responsibility between patient and physician; and

WHEREAS, no plan of socialized medicine or other form of government-sponsored health care plan can function without cooperation and participation of the majority of physicians of the involved community;

NOW, THEREFORE, BE IT RESOLVED that the members of the Indiana State Medical Association in their effort to help preserve the American system of medicine, and to thwart the promulgation of a national socialist medical system do pledge ourselves to continue to care for our patients to the best of our ability, and do hereby notify the members of the Federal Congress and the general public that we will not participate in any Federally sponsored plan of collectivized medical care now under consideration, including Senate Bill 3 or H.R. 7741, or any other such plan which may in the future be considered, if such plan includes provisions for: abandonment of fee-for-service system, forced abolition of individual patient-doctor relationship with separate responsibility, national licensure of medical practitioners, forced relocation of physicians, involuntary servitude of physicians, abridgement of the right of privileged communication between the patient and doctor, institution of compulsory peer review requirements, establishment of any Federal regulations of medical practice except in the distribution of narcotics and dangerous drugs, the removal of constitutional freedoms from any citizen.

Resolution No. 71-4

Subject: MEDICAL DEPARTMENT-BOARD OF CORRECTIONS

HOUSE ACTION: Adopted.

WHEREAS, many members of the LaPorte County Medical Society have either worked in the Michigan City prison medical department or have served as consultants and are aware of the medical needs of the inmates of the Michigan City prison; and,

WHEREAS, the LaPorte County Medical Society has annually for the past nine years recommended to the state government through the state medical association the idea of organizing the medical care in the Department of Corrections in a more efficient manner; and,

WHEREAS, a survey of the medical needs of our state prisons by the U.S. Public Health Department in 1968 confirmed this recommendation; and,

WHEREAS, the Indiana State Board of Corrections is responsible for the total care of all inmates under their supervision;

NOW, THEREFORE, BE IT RESOLVED that the LaPorte County Medical Society urges the Indiana State Medical Association to again recommend to the state government the establishment of a medical department within the Board of Corrections.

Resolution No. 71-5

Subject: STATE-WIDE MORATORIUM ON AMPHETAMINE DRUGS

HOUSE ACTION: Adopted.

WHEREAS, the medical profession recognizes the seriousness of the drug-abuse problem in this country, and,

WHEREAS, the medical profession should lead in studying and establishing solutions to the problems of drug abuse; and,

WHEREAS, the LaPorte County Medical Society has had some success, a great deal of cooperation from the pharmacists and a great deal of public relations with a program which established a three months' moratorium on the prescribing of amphetamine drugs by the members;

NOW, THEREFORE, BE IT RESOLVED that the LaPorte County Medical Society recommends to the Indiana State Medical Association that a statewide moratorium be established on the prescription of amphetamine drugs by their members except in the treatment of narcolepsy, hyperkineses and certain psychiatric problems.

Resolution No. 71-6

Subject: CHLORINE CONTENT-SWIMMING POOLS

HOUSE ACTION: Not adopted.

WHEREAS, Indiana State law requires the addition of chlorine to swimming pools in order to insure safe water for swimming; and

WHEREAS, the addition of too much chlorine to an indoor pool may result in an unhealthy level of free chlorine in the air above the pool; and

WHEREAS, this may produce bronchospasm or other respiratory difficulties in susceptible individuals; and

WHEREAS, no upper limit has been set by the State for the amount of chlorine which may be added to indoor pools;

NOW, THEREFORE BE IT RESOLVED, that the State be urged, through whatever means or mechanism may be appropriate, to establish a safe upper limit for the addition of chlorine in indoor swimming pools.

Resolution No. 71-7

Subject: INVASION OF PATIENT PRIVACY

HOUSE ACTION: Referred to Commission on Legislation for drafting amendments to be presented to the General Assembly.

WHEREAS, the State Health Commissioner, in accord with provisions of Chapter 404, Indiana Acts of 1969, has forwarded to Indiana physicians, directors and superintendents of agencies and facilities a form on which information about individuals with handicapping conditions is to be recorded; and

WHEREAS, a handicapping condition is very broadly defined therein and may include any problem of vision, hearing, speech, mental retardation, emotions or mind, chronic diseases and conditions, and physical handicaps, even extending to such conditions as unusually low voice, sinus trouble, varicose veins, or birthmarks, providing only that in the doctor's judgment said condition prevents the individual from engaging in normal life activities, and the individual can benefit from habilitation or rehabilitation services; and

WHEREAS, the requested information not only identifies an individual as handicapped, but also provides medical information which a patient would ordinarily assume to be confidential and unavailable to anyone outside his doctor's office without the express permission of the patient; and

WHEREAS, compliance with the law seems to constitute a clear invasion of the patient's privacy; and

WHEREAS, such compliance would also be an intrusion of the government into the doctor-patient relationship;

NOW, THEREFORE, BE IT RESOLVED that the Indiana State Medical Association register a protest with the State Board of Health; and

FURTHER BE IT RESOLVED that it employ any other feasible and legal means, including support of legislative action, if indicated, to safeguard the privacy of the patient and to maintain the sanctity of the doctor-patient relationship without in any way limiting the opportunity of any individual to apply for aid for handicapped persons.

Resolution No. 71-8

Subject: NEWBORN INSURANCE COVERAGE

HOUSE ACTION: Adopted as amended.

WHEREAS, it is recognized that the nation's most valuable resource is its children; and

WHEREAS, it is recommended that every infant receive quality medical supervision in the earliest period of life; and

WHEREAS, the private insurance industry, excluding Blue Shield, offers exclusion from coverage for the first fourteen days of life in many policies, and

WHEREAS, certain health problems in children are readily identified and best treated in the first days of life and, consequently, this exclusion is not for the benefit of child health nor the family's well-being;

THEREFORE, BE IT RESOLVED that orously supports the eradication of the 14-day exclusion clause from all health insurance policies sold in the state.

Resolution No. 71-9

Subject: DISASSOCIATION: ISMA-AMA

HOUSE ACTION: Not adopted.

WHEREAS, the American Medical Association no longer gives whole-hearted support in the fight against the socialistic schemes of our government; and,

WHEREAS, the American Medical Association, in lieu of fighting the socialistic schemes, has merely offered equally odious alternatives; and

WHEREAS, the hierarchy of the American Medical Association under the tutelage and leadership of Dr. Ernest Howard, who has consistently undercut various leaders in our fight against collectivism—such as Dr. Edward Annis, Dr. F. J. L. Blasingame, and Dr. Milford Rouse; and

WHEREAS, much of our monies given as dues to the American Medical Association are actually used to promote our own downfall and for innumerable publications of dubious worth to our medical profession;

THEREFORE, BE IT RESOLVED that a committee be appointed at the next regular meeting of the House of Delegates of the Indiana State Medical Association to study the advisability and feasibility of the Indiana State Medical Association disassociating itself from the American Medical Association.

The above resolution was passed by the Clinton County Medical Society at its regular, stated meeting, May 25, 1971, for submission to the House of Delegates of the Indiana State Medical Association.

Resolution No. 71-10

Subject: FORMATION — BARGAINING COMMITTEE

HOUSE ACTION: Not adopted.

WHEREAS, Indiana State Medical Association members feel the need for a bargaining committee; and

WHEREAS, third parties are approaching the Indiana State Medical Association to deal with mutual problems; and

WHEREAS, Conditions which formerly precluded such a committee are changing;

NOW, THEREFORE, BE IT RESOLVED that the Indiana State Medical Association form a bargaining committee whose action shall be to improve the Indiana State Medical Association members' economic advantage in dealing with all third parties, whether governmental or business or intermediary.

Resolution No. 71-11

Subject: SUPPORT OF ANNUAL MEETING PROGRAM

HOUSE ACTION: Adopted as amended. Referred to Budget Committee and Board of Trustees.

WHEREAS, one of the vital services of the Indiana State Medical Association to its membership is the providing of a maximal, informative and comprehensive coverage of medical, scientific and socio-economic and political trends in the practice of medicine at the Annual Convention; and

WHEREAS, speakers of unique or unusual, or comprehensive experience, national repute or recognized capacities in their respective fields of medical, scientific or socio-economic or political trends in the practice of medicine are essential to providing this maximal, informative and comprehensive coverage; and

WHEREAS, the Convention Arrangements Commission and Section Officers and those concerned with providing the program for the Annual Meeting are greatly hampered in their efforts to provide a program of maximal comprehensive coverage by the inability to offer adequate or usual and customary honorariums to the speakers;

NOW, THEREFORE BE IT RESOLVED, that the House of Delegates feels that the Commission on Convention Arrangements be provided with adequate funds for the specific purpose of honorariums for speakers at the annual meeting of the Association.

Resolution No. 71-12

Subject: AMA CODING AND NOMENCLATURE SYSTEM

HOUSE ACTION: Adopted.

WHEREAS, the need for a uniform system of coding and nomenclature in order to describe accurately the great variety of

medical services has never been greater; and

WHEREAS, the American Medical Association has prepared an accurate and current system of coding and nomenclature; and

WHEREAS, 28 state medical societies, many specialty societies, the Health Insurance Council and the World Medical Association, list attached, have adopted the AMA Current Procedural Terminology (CPT); and

WHEREAS, this is now universally used for the description of professional services;

THEREFORE, BE IT RESOLVED that the Indiana State Medical Association officially adopt this system of nomenclature of the American Medical Association; and

BE IT FURTHER RESOLVED that the ISMA House of Delegates urge Indiana Blue Shield to adopt the AMA system of coding and nomenclature as the universal system for description of medical services.

GROUPS WHICH HAVE ADOPTED CPT

State Medical Societies

Medical Association of Alabama
Arizona Medical Association, Inc.
California Medical Association
Colorado Medical Association
Medical Society of District of Columbia
Medical Society of Delaware
Florida Blue Shield Association
Florida Medical Association
Medical Association of Georgia
Illinois Public Welfare Department
Illinois State Medical Society
Kansas Medical Society
Kentucky Medical Association
Louisiana State Medical Society
Medical & Chirurgical Faculty of the State of Maryland
Massachusetts Medical Society
Michigan State Medical Society Council and House of Delegates
Mississippi State Medical Association
Montana Medical Association
Nevada State Medical Association
New Castle County Medical Society, Delaware
Medical Society of County of Monroe, New York
North Carolina Blue Shield
North Carolina Society of Internal Medicine
Ohio State Medical Association
Oklahoma State Medical Society
Oregon Medical Association
Rhode Island Medical Society House of Delegates
Tennessee Medical Association
Board of the Texas Medical Association
Utah State Medical Association
Medical Society of Virginia
Washington State Medical Association
State Medical Society of Wisconsin

Medical Specialties

American Academy of Family Physicians
American Society of Internal Medicine
American Association of Neurological Surgeons
American Academy of Neurology
American College of Obstetricians and Gynecologists
American Academy of Ophthalmology and Otolaryngology
American Association of Ophthalmologists
American Academy of Orthopedic Surgeons
Norwich Orthopaedic Group, Connecticut
College of American Pathologists
American Academy of Pediatrics
American College of Physicians
American Society of Plastic & Reconstructive Surgeons
American Proctologic Society
American Psychiatric Association
American College of Radiology
American Urological Association
Pennsylvania Academy of Ophthalmology and Otolaryngology

Special Groups

Health Insurance Council
World Medical Association

Resolution No. 71-13

Subject: QUALIFIED TRAINERS IN SPORTS ACTIVITIES

HOUSE ACTION: Adopted.

WHEREAS, contact sports can cause sudden serious injury to the participants; and

WHEREAS, such injury can occur in practice as well as under actual game conditions; and

WHEREAS, a physician cannot always be available at said practices and games; and

WHEREAS, a qualified trainer can give necessary emergency aid until a physician can be obtained; and

WHEREAS, such qualified individuals are not available in adequate numbers in the State of Indiana,

NOW, THEREFORE, BE IT RESOLVED that the Indiana State Medical Association recommend that the Superintendent of Public Instruction endorse the development of an athletic trainer educational program in all Indiana teacher training institutions;

BE IT FURTHER RESOLVED that the Indiana State Medical Association recommend that the Indiana High School Athletic Association and individual County Medical Societies encourage each school participating in competitive athletic programs to employ such qualified trainers as they become available.

Resolution No. 71-14

Subject: CONTINUING MEDICAL EDUCATION REQUIREMENTS FOR INDIANA STATE MEDICAL ASSOCIATION MEMBERSHIP

HOUSE ACTION: Adopted as amended.

WHEREAS, the "Indiana Plan" has apparently succeeded in attaining one of its goals—that of increasing the supply and quality of continuing medical education in Indiana, and

WHEREAS, Indiana continues to be a leader and innovator in medical education, and

WHEREAS, all specialty societies are now studying the feasibility of reboarding, and

WHEREAS, continuing medical education appears to be vital if physicians are to keep abreast, and

WHEREAS, there is now a national mechanism for registering continuing medical education experiences (Physician's Recognition Award) available to all doctors, and

WHEREAS, several states, i.e., Oregon, New Mexico, Arizona, Pennsylvania, and now Ohio have enacted programs including the requirement of continuing medical education programs for state licensure (New Mexico) and membership (all others), and

WHEREAS, the House of Delegates asked that a similar proposal be developed (1970);

THEREFORE, BE IT RESOLVED,

1. That the Commission on Medical Education and Licensure establish a statewide mechanism for accrediting non-university programs following the guidelines of the Physician's Recognition Award,

2. That all such programs be annually re-evaluated and published for the information of the membership,

3. That the Indiana University School of Medicine be commended for the quality and quantity of programs offered and that the school be encouraged to continue its excellent cooperation and that it attempt to offer as many programs as possible out of the Indianapolis area,

4. That adjacent areas strive to coordinate their efforts to avoid reduplication in establishing programs,

5. That the Commission should continuously assure itself that the programs being offered are tailored to meet the needs of the physicians,

6. That when the above have been accomplished, the House of Delegates of the Indiana State Medical Association be requested to encourage participation in a continuing medical education program to fulfill the requirements of the Physician's Recognition Award,

7. That the accreditation program should be completed by April of 1972, allowing action by the House of Delegates in the fall of 1972,

8. That all of the above be implemented based on the conviction that a program of continuing medical education will result in improved quality of patient care.

Resolution No. 71-15

Subject: STATEWIDE CONTINUING MEDICAL EDUCATION ACCREDITATION SYSTEM

HOUSE ACTION: Adopted as amended.

WHEREAS, continuing medical education in the U.S.A. is fragmented and uncoordinated, and

WHEREAS, little is being done to study local and statewide continuing medical education programs as to what is wanted and needed by the practicing physicians, and

WHEREAS, the American Medical Association Council on Medical Education has suggested that states accredit their own continuing medical education program, and

WHEREAS, Indiana University Medical Center has in the past and continues to provide continuing medical education to most areas of Indiana, and

WHEREAS, a more coordinated effort is necessary in Indiana to assure adequate, appropriate, high quality continuing medical education to all practicing physicians in Indiana,

THEREFORE, BE IT RESOLVED, THAT

1. The Commission on Medical Education and Licensure develop a sub-committee on continuing medical education,

2. This subcommittee be made up of
   a. Chairman or representative of the Department of Continuing Medical Education—Indiana University Medical Center
   b. Association of Indiana Directors of Medical Education representative
   c. Representative from each specialty society that has a regular committee on continuing medical education in Indiana

3. This subcommittee be charged with the development of a statewide continuing medical education accreditation system following guidelines developed by the Commission on Medical Education and Licensure, and

4. This subcommittee report be sent to the Commission on Medical Education and Licensure by April, 1972.

Resolution No. 71-16

Subject: REDEFINING MEDICAL DISTRICTS—CHANGE IN BYLAWS

WHEREAS, Jasper County is desirous of being included in the 9th Medical District of the Indiana State Medical Association, instead of the 10th Medical District; and

WHEREAS, Jasper County, being a rural agricultural area, feels it has more in common with the rural agricultural areas encompassed by the county societies in the 9th District; and

WHEREAS, we feel our interest in medical organization activities would be improved by establishing a professional relationship with similar counties currently in the 9th District;

THEREFORE, BE IT RESOLVED that the Jasper County Medical Society hereby petitions the House of Delegates of the Indiana State Medical Association to transfer said society from the 10th to the 9th Medical District; and

BE IT FURTHER RESOLVED that Chapter XXXII, Section 2, of the Bylaws of the Indiana State Medical Association be amended to show Jasper County a member of the 9th Medical District and delete its listing from the 10th Medical District. Chapter XXXII, Section 2 will then read as follows:

> "Sec. 2. The state shall be divided into thirteen (13) Trustee Districts with the boundary lines and numbers of each district to be as follows:
> "First District—***
> "Second District—***
> "Third District—***
> "Fourth District—***
> "Fifth District—***
> "Sixth District—***
> "Eighth District—***
> "Ninth District—Fountain, Montgomery, Boone, Hamilton, Tipton, Clinton, Tippecanoe, Warren, Benton, White, Newton, and Jasper.
> "Tenth District—Porter and Lake Counties.
> "Eleventh District—***
> "Twelfth District—***
> "Thirteenth District—***"

Resolution No. 71-17

Subject: STATE-WIDE MORATORIUM ON AMPHETAMINE DRUGS

HOUSE ACTION: Adopted.

WHEREAS, the Medical Profession recognizes the seriousness of the drug abuse problem in this county, and

WHEREAS, the Medical Profession should lead in studying and establishing solutions to the problem of drug abuse, and

WHEREAS, the Daviess - Martin County Medical Society has gone on record, and is carrying out the program, of not prescribing amphetamine drugs except in the treatment of narcolepsy or hyperkinesia, this society proposes the following resolution:

BE IT RESOLVED that the Daviess - Martin County Medical Society recommends to the Indiana State Medical Association that a state-wide moratorium be established of not prescribing amphetamine drugs by their members, except in the treatment of narcolepsy, hyperkinesia, and some psychiatric conditions.

Resolution No. 71-18

Subject: FEDERAL LEGISLATION BY-PASSING LOCAL HEALTH DEPARTMENTS

HOUSE ACTION: Adopted as amended.

WHEREAS, contemplated and existing federal health legislation proposes to bypass existing official public health resources at all levels now employed in consumer preventive and protective services, and

WHEREAS, the Indiana Association of Public Health Physicians, Inc., has requested support in the development of procedures for integrating existing public health resources into future patterns of health care, and

WHEREAS, most official personnel resources reside in operational local health departments, and

WHEREAS, local health departments are the sole official agencies totally devoted to public health, and

WHEREAS, federal legislation is increasingly duplicating and fragmenting the local administration of public health funds, expertise and personnel resources,

THEREFORE, BE IT RESOLVED, that the House of Delegates of the Indiana State Medical Association urge that all legislative programs providing for comprehensive health care insure stability and continuity through involvement of state, county and city health departments.

Resolution No. 71-19

Subject: PARAMETERS FOR MEDICARE AND MEDICAID SERVICES

HOUSE ACTION: Adopted as amended.

WHEREAS, Blue Shield has advised Indiana physicians of parameters established by the U.S. Department of Health, Education and Welfare in regard to Medicare and Medicaid services, and

WHEREAS, the parameters limit severely the charges allowable for physician visits to Medicare and Medicaid patients in nursing homes, ostensibly to curb abuses by a few physicians, and

WHEREAS, such parameters are unnecessarily restrictive for doctors attempting to provide good medical care for those patients, and

WHEREAS, if the Department of Health, Education and Welfare has evidence of irregularities in the practices of a few physicians there are adequate avenues for their correction other than by indicting, at least by indirection, the entire profession, and by diverting the onus of unfulfilled political promises to the shoulders of physicians who long ago warned of underestimated costs and other pitfalls,

THEREFORE, BE IT RESOLVED that the House of Delegates of the Indiana State Medical Association inform the Department of Health, Education and Welfare that such parameters are not conducive to good medical care and are unacceptable to members of the Association.

Resolution No. 71-20

Subject: FOUNDATIONS AND HEALTH MAINTENANCE ORGANIZATIONS

HOUSE ACTION: Not adopted.

WHEREAS, county and state medical societies throughout the nation are being importuned to form foundations and health maintenance organizations, and

WHEREAS, such groups are proliferating but have embarked on a variety of courses (to provide for peer review, or to provide medical care for certain segments of the population on a capitation basis, for example) and

WHEREAS, hastily contrived organizations and systems would not be in the best interests of either physician or patient and, indeed, could serve as instruments to divide the medical profession.

THEREFORE, BE IT RESOLVED that the House of Delegates direct the Board of Trustees of the Indiana State Medical Association to establish guidelines for county medical societies to follow in event they desire to form such organizations.

Resolution No. 71-21

Subject: REIMBURSEMENT OF PHYSICIANS SERVING ON MANDATED COMMITTEES

HOUSE ACTION: Not adopted.

WHEREAS, under Medicare - Medicaid certain physicians are mandated by law to spend considerable time reviewing patients and their charts in hospitals and nursing homes, and

WHEREAS, all other agents or agencies set up by law to administer Medicare-Medicaid programs receive appropriate compensation, and

WHEREAS, such mandated committee services represents a further drain on sorely needed medical manpower

BE IT RESOLVED that the Indiana State Medical Association go on record as favoring the principle that physicians serving on such mandated bodies be properly compensated for the time involved, and that such physicians are justified in billing the involved institution (Hospital or Nursing Home) for their services. The involved institution would be justified in seeking reimbursement from the governmental agency mandating such physicians services

BE IT FURTHER RESOLVED that in the future, should other committees be formed where physicians' services be mandated by law, that such physician committee members be entitled to similar appropriate reimbursement.

Resolution No. 71-22

Subject: S.S.A. STANDARDS ON DISABILITY

HOUSE ACTION: Not adopted.

WHEREAS, the Indiana State Medical Association is unalterably adherent to the policy that the doctors of Indiana, as members of the Indiana State Medical Association give the very highest quality of medical treatment available, and,

WHEREAS, there seems to be considerable inequity in the regulations of the Social Security Disability Provisions, namely that a person is either well and able to work fully or totally and possibly, permanently disabled, prior to being able to be considered for compensation, and,

WHEREAS, there are many people who are able to do some work or who have because of the nature of their work, reached an age where their usual and customary life work is no longer feasible, but they do not suffer from total emotional or physical disability, and,

WHEREAS, we are convinced that a person's self esteem is dependent on his ability to be as independent and self sustaining as his total evaluation will allow,

WHEREAS, newer knowledge and experience has been developed to enable trained professionals to evaluate impairment and classify inability as opposed to disability.

NOW, THEREFORE BE IT RESOLVED, that the principle of partial inability to carry out their usual occupation whether it be due to age, disability of a physical, or emotional nature; be considered as an alternative to be adjudged to being totally disabled and unable to work. This policy would also be for a period where the person could work within the limits of his ability, and would have opportunities for rehabilitation that are not encouraged by the total disability concept. It is our opinion that this would be economical in that it would encourage rehabilitation.

Resolution No. 71-23

Subject: RECENT THIRD PARTY ACTIVITIES CONCERNING GRADUATE MEDICAL EDUCATION

HOUSE ACTION: Adopted substitute resolution for No. 71-23, as amended.

WHEREAS, hospital based graduate medical education in the state of Indiana is fiscally supported by the general funds of the providing hospital and these operating funds are derived largely from patient sources and third party organizations.

WHEREAS, the Section of Directors of Medical Education of the Indiana State Medical Association has learned that two major carriers of hospital insurance are refusing to permit usual and customary professional fees because the hospitals have graduate medical education programs; the Section believes that all hospital based graduate medical education programs are thereby financially endangered. Also the quality of medical care could be significantly decreased, and

THEREFORE BE IT RESOLVED, that the Indiana State Medical Association instruct its appropriate officers and committees to study this serious threat for the purpose of: (1) assuring that the future quality of medical care will not be

damaged by the actions of third party agencies, and (2) assuring that hospital-based graduate medical education programs will be soundly and securely financed through encouragement of more use of public sources and finances, and (3) assuring that the community of the state of Indiana will be able to continue and to enhance its physician-developed, hospital-based medical education programs, expressed in strong and enthusiastic support of the Indiana Plan and the Seven Centers Program of Indiana.

Resolution No. 71-24

Subject: FLOW OF ILLICIT DRUGS FROM COMMUNIST CHINA

HOUSE ACTION: Referred to Board of Trustees for further study.

WHEREAS: The rising problem of drug abuse, especially narcotics, is of increasing concern to all Americans and especially to physicians, AND

WHEREAS: The United States government with state and local help has many established programs to combat this problem. AND

WHEREAS: President Nixon, recognizing the urgency of the situation, has taken active and positive leadership in introducing his four point "national offensive on this problem" including: curbing drug sources, prosecuting pushers, rehabilitating addicts, and educating the public. AND

WHEREAS: China has long produced opium as a cash crop and Communist China, since 1951, has exported opium as a national policy and maintains a Cabinet Officer in charge of their world-wide illegal drug traffic until they are now the world's foremost producer of opiates. AND

WHEREAS: As physicians we must oppose any actions detrimental to the health and well-being of our patients and oppose any activities which would increase the dangers of greater narcotic traffic. AND

WHEREAS: President Nixon's proposed visit to Communist China could pave the way for U.S. recognition and for U.N. participation by these international criminals, resulting in increased opportunities for their smuggling which would result in undermining efforts to curb this illegal traffic. THEREFORE:

BE IT RESOLVED THAT: We, the members of the Indiana State Medical Association respectfully request President Nixon to specify as one of the conditions for his visiting Communist China that it join with other nations in combating rather than promoting the narcotics traffic. AND

BE IT FURTHER RESOLVED THAT: This resolution be forwarded to the American Medical Association for their consideration and concurrence.

Resolution No. 71-25

Subject: HEALTH MANPOWER

HOUSE ACTION: Adopted as amended.

WHEREAS, There are many citizens of this State and Nation in even large communities without a physician;

WHEREAS, The armed services hold all our new doctors for a 2-4 year period of military duty while in peace time;

WHEREAS, We in Medicine feel this is a waste of medical manpower;

RESOLVED, That we ask the U.S. Defense Department to credit M.D.'s for military service if they practice medicine in areas of critical need and that this service be accepted as fulfillment of military obligations.

FURTHER BE IT RESOLVED, that this notice of action be sent to the AMA and ask national support.

Presidential Resolution

HOUSE ACTION: Adopted by acclamation.

WHEREAS, the presidency of the Indiana State Medical Association is an office demanding time involvement, sacrifices of family and relinquishment of a great deal of personal freedom, and

WHEREAS, not only has the current president given of himself unselfishly in the best traditions of a conscious and dedicated individual, and has displayed continuously during his official term a concern for unifying the profession, and

WHEREAS, exhibits to a multitude of county societies has resulted in a deep appreciation of him on their part and a demonstrative improvement in understanding our societies and the individual physician of organized medicine's role in their professional lives,

NOW THEREFORE BE IT RESOLVED, that this House of Delegates express its utmost thanks and appreciation to Malcolm O. Scamahorn, M.D., and wish him well in the years ahead.

Resolution of Appreciation

Adopted by acclamation.

Resolution to Murat Temple, Shrine Club and Hilton Hotel.

WHEREAS, any convention to function efficiently must have the cooperation of the staff of many involved organizations, and

WHEREAS, the facilities staffed by these individuals must be adequate and comfortable to insure the utmost in events and programs, and

WHEREAS, the facilities in Indianapolis have functioned extremely well in all these vital areas,

NOW THEREFORE BE IT RESOLVED, that this House of Delegates expresses its thanks to the management of the Murat Temple, the Shrine Club and the Hilton Hotel for the excellence of their support and cooperation in the making of the 122nd Annual Convention a successful one.

Place of Future Annual Conventions

1972 — Indianapolis
1973 — Indianapolis
1974 — Indianapolis
1975 — Indianapolis
1976 — Indianapolis

Adjournment

The House of Delegates adjourned, sine die, at 6:20 p.m., Thursday, October 14, 1971. ◄

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The JOURNAL

of the

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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